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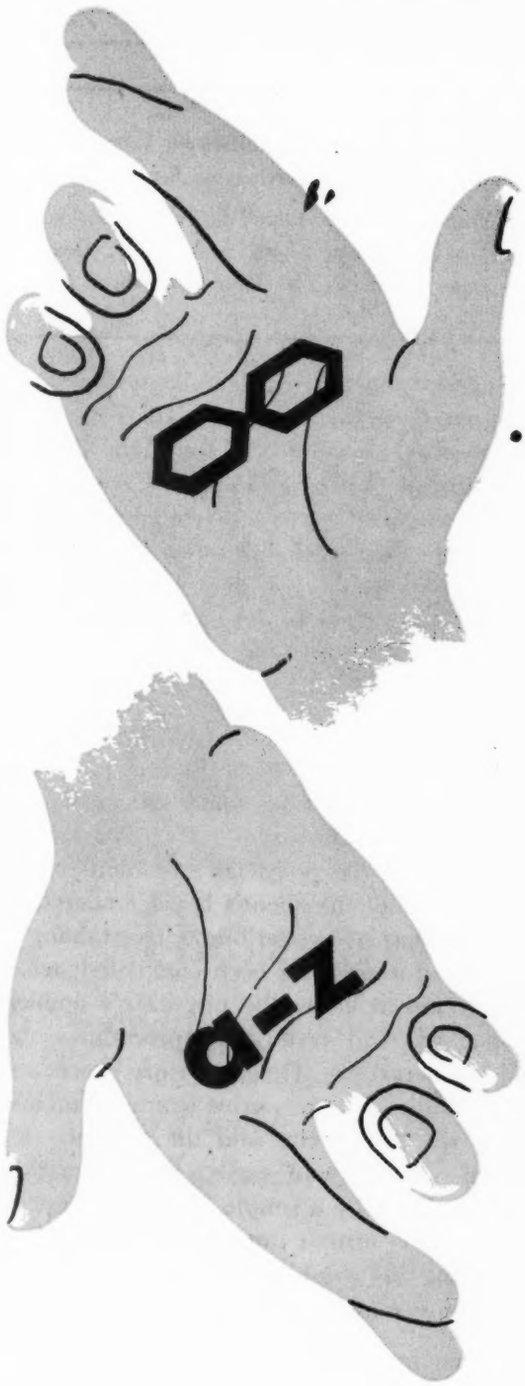
Henry R. Carstens, M. D.
Detroit
MSMS President
1941-1942



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You and Your Business

DUES OF MEDICAL VETERANS

1. The Michigan State Medical Society will remit the 1946 dues of all medical veterans who were members in good standing of any other state medical society and who transfer their membership to the Michigan State Medical Society in 1946. The arrangement for military members of the Michigan State Medical Society will apply in these cases.

2. The MSMS Council has also ruled that returning medical veterans, regardless of prior membership in the Michigan State Medical Society (because of their internship or residency or similar educational status) shall be accorded privileges as military members in the Michigan State Medical Society, with remission of dues. Their status is to be determined wholly on the date of their discharge from military service, certified by the county medical society in whose area they are practicing.

Listen! Augmented Michigan Radio Network
Every Tuesday, 8:15 P.M.
MSMS Commercial Radio Program!

MSMS ANNUAL SESSION, 1946

September 25, 26, 27, 1946, are the dates of the MSMS Annual Scientific Session this year.

The place will be the Book-Cadillac Hotel, Detroit.

The House of Delegates will convene one day earlier than usual, on Sunday, September 22, 8:00 P.M., and continue their deliberations through Monday and Tuesday, as necessary.

The Woman's Auxiliary of the Michigan State Medical Society will meet at the Statler Hotel on Wednesday and Thursday, September 25 and 26, 1946.

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MEDICAL BLANKS FOR VOCATIONAL REHABILITATION

Every client of Vocational Rehabilitation must have a basic medical report to establish his or her eligibility for service. Rehabilitation of disabled persons would be unsound in the extreme if not based upon competent medical diagnosis and proper treatment, according to B. H. Van Leuven, M.D., medical consultant of the State Vocational Rehabilitation Division. Thus it is apparent that the basic medical report is an important primary step in the client's rehabilitation. It is felt that many physicians do not understand the importance of completely filling out the blank. The form itself is short and the proper execution consumes but a small part of the physician's time.

The U. S. Senate Committee on Education and Labor has scheduled hearings on Senate Bill 1606, the Wagner-Murray-Dingell Bill (Socialized Medicine) to commence Tuesday, April 2. Hearings are expected to run for about thirty days.

The important item on the form is the diagnosis, the rest of the blank, with the exception of the laboratory tests, can be filled out by "yes" or "no" answers for the most part. Rehabilitation wants to know the physician's opinion regarding the possibility of the client's being rendered fit to take a job that will make him self-sustaining after physical restoration has been completed; rehabilitation wants to know the physician's opinion as to what physical restoration procedures should best be undertaken. The laboratory procedure required is simple—only a urine examination involving the specific gravity and the presence or absence of albumin and sugar, and estimation of the hemoglobin by a simple Tallqvist's test. This form is of the utmost importance to the client in establishing his eligibility to the services of Rehabilitation and in assuring adequate medical care.

The fee for filling out the blank is $5.00 and billing forms are furnished the physician along with the blank. Payment is prompt in each case upon receipt of the bill by the State Vocational Rehabilitation Division, Bauch Bldg., Lansing.

Listen! Augmented Michigan Radio Network
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MSMS Commercial Radio Program!

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(Continued from Page 278)

MEDICAL FACULTY MEMBERS RETURN

Three members of the Wayne University College of Medicine faculty have resumed their positions after extended leaves of absence with the Army, Dean Hardy A. Kemp announced. Those back are Dr. James M. Winfield, Dr. Arthur W. Frisch, and Dr. Luverne H. Domeier.

Dr. Winfield, who has taken up his former post as associate professor of surgery, left the College of Medicine in October, 1942, with personnel of the 36th General Hospital, an organization composed of Wayne University staff members. Commissioned a lieutenant colonel in charge of the surgical service, Dr. Winfield spent over two years with his unit in both the Mediterranean and European Theaters. Prior to his discharge last fall, Dr. Winfield was appointed full colonel and decorated with the Legion of Merit and the Distinguished Unit Badge.

Dr. Frisch, associate professor of bacteriology and clinical pathology, received his discharge from the Army Medical Corps last month after serving in laboratory epidemiological research for over three years. Until April, 1945, he engaged in research at Percy Jones Hospital, Battle Creek, and then was transferred to the Army Epidemiological Board in Ann Arbor.

Dr. Domeier, who has returned as instructor in pathology, entered the Army in September, 1942. A captain in the Medical Corps, he was stationed for three years at Third Air Force hospitals in Louisiana and Florida.

Listen! Augmented Michigan Radio Network
Every Tuesday, 8:15 P.M.
MSMS Commercial Radio Program!

ASSOCIATED PRESS POLL OF CONGRESSMEN

The Associated Press, as reported by Science writer Carey, conducted a poll of the Congressmen just before the Christmas vacation asking this question:

> "Do you favor President Truman's proposal for a national prepaid 'health insurance' plan to be financed by additional social security taxes and by general government revenues?"

One hundred forty-one ballots were returned. Of these seventy-two voted "No"; forty-three voted "Yes"; seventeen were undecided; three were "non-committal" and six others gave qualified answers.

Of the seventy-five designated Republicans who returned ballots, only four expressed themselves in favor of the Truman proposal; nine were undecided; three were non-committal and one said that while he was against it at present, if modifications were made perhaps he would go along. Of the sixty-three designated Democrats, thirty-eight were for the proposal; twelve were opposed; eight were undecided and five gave qualified answers.

RADIO PROGRAM OF MICHIGAN STATE MEDICAL SOCIETY

Recently the Special Committee on Radio of the Michigan State Medical Society conducted two surveys on our radio program which has been broadcasted on Radio Station WJR for the past year at 6:30 P.M. each Friday.

The first survey was made by Commercial Services, Inc., a firm which makes a business of commercial radio polls.

This poll is done by having forty experienced telephone operators call as many people as they can while the program is on. These operators, who are not told who they are working for and omit all physicians from their calls asked the following questions:

1. Is your radio turned on?
2. To what radio station are you listening?
3. Who is the sponsor of the program?

Much to the surprise of our Radio Committee and Station WJR our rating was 9.6 which compares favorably with some of the National programs which have run for years and cost a lot more money. Some of these programs and their Hooper rating are as follows:

HOOPER RATING
May through September, 1945

Manhattan Merry Go Round	9.9
American Album Familiar Music	10.2
Morton Downey	1.8
Hour of Charm (eleven years)	10.8
Breakfast in Hollywood	11.4
Firestone Concert	9.2
Information Please	7.5
Chicago Breakfast Club	6.7
Lone Ranger	5.9
Kate Smith	11.6
Quizz Kids	9.8
Prudential Family Hour	5.6
Wayne King	9.3
Crime Doctor	10.5
James Melton	8.0
Double or Nothing	3.4
Frank Sinatra	10.6
Preston Slosson	10.0

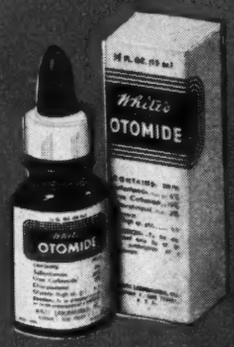
The second survey was made by sending a two-way postcard to the membership of the MSMS. Of those who voted, 83.9 per cent were in favor of the program. Many also sent in constructive ideas for improving the program.

The new radio program started on Tuesday, March 5, 1946.

Time, 8:15-8:30 P.M.

WXYZ	Detroit
WLAF	Grand Rapids
WIBM	Jackson
WKBZ	Muskegon
WFDF	Flint
WSOO	Sault Ste. Marie
WDBC	Escanaba
WBCM	Bay City
WDMJ	Marquette
WELL	Battle Creek
WJMS	Ironwood
WTCM	Traverse City
WJIM	Lansing (10:00-10:15 P.M.)

for topical Otologic chemotherapy



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offers these unique clinical advantages

POTENTIATED ANTIBACTERIAL POTENCY
urea-sulfanilamide mixture more effective than either drug used independently.[1] Not inhibited by pus.

BETTER TISSUE DIFFUSION
more active diffusion of sulfanilamide through living and dead tissues due to urea content.[2]

INCREASED PHYSIOLOGIC DEBRIDEMENT
local therapy with urea in chronic otitis media brings about "a more adequate removal of the gross and microscopic debris in the recesses of the middle ear."[3]

WIDE FIELD
effective in BOTH acute AND chronic otologic infections. Active against sulfonamide-resistant bacteria.[4]

WELL TOLERATED
freedom from alkalinity virtually obviates local irritation.

ANALGESIC
provides effective chlorobutanol analgesia without impaired sulfonamide activity.

White's Otomide presents a stable, non-irritating solution of sulfanilamide, urea and chlorobutanol in a glycerin vehicle of unusually high hygroscopic activity.

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AVAILABLE IN DROPPER BOTTLES OF ONE-HALF FLUID OUNCE (15 cc.) ON PRESCRIPTION ONLY

1. *Tsuchiya, H. M., et al.: Proc. Soc. Exp. Biol. and Med., 50:262, 1942.*

2. *McClintock, L. A. and Goodale, R. H.: U. S. Naval Med. Bull., 41:1057, 1943.*

3. *Mertins, P. S. Jr.: Arch. Otolaryng., 26:509, 1937.*

4. *Strakosch, E. A. and Clark, W. G.: Minn. Med., 26:276, 1943.*

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrom ignoramus—Old Maxim

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL. B., General Counsel MSMS
Manistique, Michigan

NURSES—DELEGATION OF AUTHORITY—INTRAVENOUS INJECTION OF DRUGS

Recently J. C. Droste, M.D., Secretary of the Executive Committee of Saint Mary's Hospital, Grand Rapids, Michigan, requested the writer's opinion relative to the following question: "How far may a hospital go in delegating to nurses the intravenous injection of drugs?" As I thought this subject might be of general interest to the medical profession, the opinion rendered is quoted below.

"Although a hospital may require the nurses on its staff to be trained and qualified to give intravenous injections, it is well known that a hospital may not 'delegate' the administering of drugs to patients by such methods, or any other. That authority, of course, rests exclusively with physicians. We shall therefore assume the real question to be whether nurses may on instruction of physicians lawfully give intravenous injections of drugs to patients at the hospital.

"Section 14.690, Michigan Statutes Annotated, defines the term 'registered nurse' as follows:

"Unless otherwise provided in this act the term 'registered nurse' is defined as one who has been authorized by the state to nurse or administer to the sick or those afflicted with any human ailment, defect, or complaint, whether of physical or mental origin, by attendance or advice or by the use of any therapeutic agent, under the supervision and direction of a registered physician."

"Inasmuch as the statute clearly gives the nurse authority to use 'any therapeutic agent' in administering to the sick, we need only examine her right to use the agent by means of intravenous injection.

"The statute contains no limitation on the method of use. The obvious reason for such lack of limitation is to be found in the provision that the right of a nurse to administer therapeutic agents may be exercised only under supervision and direction of a registered physician.

"A similar question, as to the right of a nurse to administer anaesthetics, was in 1939 referred to the Attorney General of Michigan for opinion. In holding that a nurse may legally give anesthetics under the supervision and direction of a registered physician, the Attorney General had reliance on the section of statute above quoted, and on the general practice in many noted hospitals by eminent surgeons of allowing nurses to administer anaesthetics.

"See Biennial Report of the Attorney General 1939-40, Page 308.

"It is common knowledge that the use of therapeutic agents has changed and advanced with discoveries of new and superior agents and methods for the alleviation of human ailments. Over the years the training and duties of nurses have generally kept pace with the uses of these new agents and methods, so that today nurses commonly administer many therapeutic remedies unheard of but a few years ago.

"There is nothing novel or unusually dangerous in making intravenous injections generally. Indeed, as Dr. Droste points out in his letter, 'Nurses have always been permitted to administer sedatives and opiates hypodermically and many of them have been trained to do the intravenous injection of whole blood, plasma, glucose and saline solutions.'

"It is my opinion therefore, that registered nurses may lawfully administer drugs by intravenous injections under the supervision and direction of registered physicians.

"In this connection it should be borne in mind, however, that there is a duty on part of the hospital and the physician to use reasonable care in selecting nurses who are qualified to administer drugs in such manner."

CORRECTION

Central Lake, Michigan, has a physician, Don Hastings Duffie, M.D., who has practiced there for the past twenty years.

Kalkaska, Michigan, also has a physician, H. V. Hendricks, M.D., who has practiced there for many years.

The list on page 212 of the February JMSMS indicating "Areas With No Physicians" included Central Lake and Kalkaska. These names were reported in error.

JOUR. MSMS

MASTER BUILDERS *of* ENDOCRINOLOGY

JOHN JACOB ABEL
1857-1938

John Jacob Abel stands high among the pioneers who helped to elevate American scientific medicine to the place it now occupies.

In 1897 he isolated a benzoyl derivative of the active principle of the adrenal medulla (epinephrine).

The Master Builders of medical and allied sciences have contributed a rich legacy of literature, techniques, and materials wherewith the human spirit may reach to all the horizons appropriate to it.

The management and staff of The Harrower Laboratory, Inc., feel that they can do no less than follow their original creed:

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AMA Offers Voluntary Medical Care Plan for United States

The Board of Trustees of the American Medical Association, at an epochal meeting in Chicago on February 12, announced the development of a nation-wide voluntary plan of prepaid group medical care.

The voluntary sickness insurance plan (not socialized medicine) is built around locally administered medical care plans already existing in twenty-five states. It provides for free choice of doctors.

The AMA Board of Trustees also established a division of Prepayment Medical Care Plans under the Council on Medical Service.

This division will consist of a director and staff to work with the various state and county societies in developing plans anywhere in the forty-eight states of the Union. The staff personnel will be experienced in all phases of organization and operation of the various types of medical care plans.

1. Any medical-care plan which meets standards set by the AMA's Council on Medical Service and is approved by the local state or county medical society may display the seal of acceptance of the American Medical Association.

2. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must be operated to provide the greatest possible benefits in medical care to the subscriber.

3. A voluntary federation known as Associated Medical Care Plans, Inc., was organized to coordinate all plans that meet the AMA council's minimum standards.

Sixty-two plans featuring voluntary prepayment medical care and approved by state and county medical societies already exist in the United States. They are:

Alabama Hospital Service Association
Birmingham, Alabama

California Physicians' Service
San Francisco, California

Hospital Service of California
Oakland, California

Intercoast Hospitalization Insurance Association
Sacramento, California

Colorado Medical Service, Inc.
Denver, Colorado

Connecticut Medical Service
New Haven, Connecticut

Delaware Medical Care Plan
Wilmington, Delaware

Group Hospital Service, Inc.
Wilmington, Delaware

Iowa Medical Service
Des Moines, Iowa

Kansas Physicians' Service
Topeka, Kansas

Hospital Service Association of New Orleans
New Orleans, Louisiana

Massachussetts Medical Service
Boston, Massachusetts

Michigan Medical Service
Detroit, Michigan

Surgical Care, Inc.
Kansas City, Missouri

Missouri Medical Service
St. Louis, Missouri

Nebraska Surgical Plan
Omaha, Nebraska

New Hampshire Physicians' Service
Concord, New Hampshire

Medical-Surgical Plan of New Jersey
Newark, New Jersey

Western New York Medical Plan, Inc.
Buffalo, New York

United Medical Service, Inc.
New York, New York

Central New York Medical Plan, Inc.
Syracuse, New York

Medical and Surgical Care, Inc.
Utica, New York

Hospital Saving Association of N. Car.
Chapel Hill, North Carolina

Medical Service Association, Inc.
Durham, North Carolina

Hospital Care Association
Durham, North Carolina

Medical Mutual of Cleveland, Inc.
Cleveland, Ohio

Ohio Medical Indemnity, Inc.
Columbus, Ohio

Community Surgical Plan
Toledo, Ohio

Oklahoma Physicians Service
Tulsa, Oklahoma

Pacific Hospital Association
Eugene, Oregon

(Continued on Page 310)

"...sulfathiazole gum provides a method of chemotherapy for oropharyngeal use and is topical in a strict sense of the term, as shown by the extremely low blood levels of sulfathiazole resulting from intensive dosage with the preparation."

—FOX, NOAH, ET AL.: EFFECT OF SULFATHIAZOLE IN CHEWING GUM IN CERTAIN OROPHARYNGEAL INFECTIONS, ARCH. OF OTOLARYNGOLOGY, *41*:278-283 (APRIL) 1945.

When a single tablet of pleasantly flavored Sulfathiazole Gum is chewed for one-half to one hour it provides a high salivary concentration of locally active sulfathiazole averaging 70 mg. per cent. Moreover, resultant blood levels of the drug, even with maximal dosage, are so low (rarely reaching 0.5 to 1 mg. per cent) that systemic toxic reactions are virtually obviated.

INDICATIONS: Local treatment of sulfonamide-susceptible infections of oropharyngeal areas; acute tonsillitis and pharyngitis—septic sore throat—infectious gingivitis and stomatitis — Vincent's infection. Also indicated in the prevention of local infection secondary to oral and pharyngeal surgery.

DOSAGE: One tablet chewed for one-half to one hour at intervals of one to four hours, depending upon the severity of the condition.

If preferred, several tablets—rather than a single tablet—may be chewed *successively* during each dosage period without significantly increasing the amount of sulfathiazole systemically absorbed.

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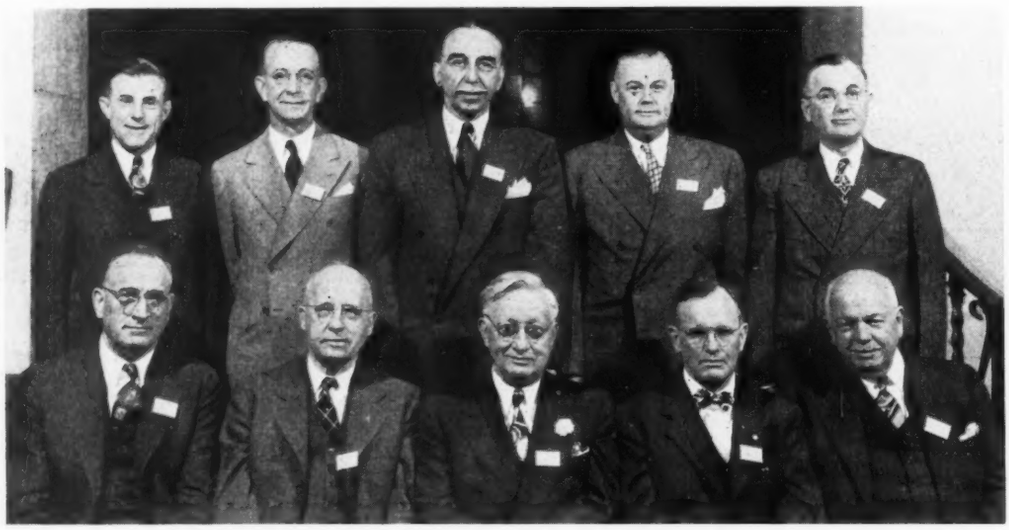
Forty-Two States Represented at Chicago Conference of Presidents

When President A. S. Brunk, M.D., Detroit, convened the First Annual Conference of Presidents and Other Officers of State Medical Associations in Chicago on December 2, 1945, 208 registrants from forty-two states were present.



PRESIDENTS-ELECT OF STATE MEDICAL SOCIETIES AT CHICAGO CONFERENCE OF PRESIDENTS, DECEMBER 2, 1945

(Seated): C. M. Hamilton, M.D., Tennessee; R. L. Parker, M.D., Iowa; E. G. Johnson, M.D., Nebraska; R. H. Chaney, M.D., Georgia; F. G. Scammell, M.D., New Jersey.
(Standing): S. J. McClendon, M.D., California; C. B. Gibson, M.D., Connecticut; W. A. Hyland, M.D., Michigan; Ross Wright, M.D., Washington; J. K. Avent, M.D., Mississippi.

This significant effort in medical public relations bore rich fruit. Its four resolutions on (a) Expansion of Medically-Sponsored Voluntary Group Health Care Programs; (b) On Modern Medical Public Relations; (c) On Formation of a National Health Congress; and (d) On Health Legislation Beneficial to the People were approved three days later by the House of Delegates of the American Medical Association. By-Laws, making the Conference of Presidents a permanent organization, were adopted. The State of Michigan and Dr. Brunk were honored by his election as the First President of the Conference of Presidents and Other Officers of State Medical Associations.

A list of those attending the Chicago Conference of Presidents includes:

Irvin Abell, M.D., Louisville, Kentucky; A. W. Adson, M.D., Rochester, Minnesota; Dwight Anderson, New York, New York; George Anderson, M.D., Spokane, Washington; W. P. Anderton, M.D., New York, New York; E. Vincent Askey, M.D., Los Angeles, California; James K. Avent, M.D., Grenada, Mississippi.

John L. Bach, Chicago, Illinois; H. Martin Baker, Wichita, Kansas; Creighton Barker, M.D., New Haven, Connecticut; W. H. Battleson, Kansas City, Missouri; William Bates, M.D., Philadelphia, Pennsylvania; Louis H. Bauer, M.D., Hempstead, New York; Jacob J. Berman, M.D., Trenton, New Jersey; R. D. Bernard, M.D., Clarion, Iowa; Walter S. Bierring, M.D., Des Moines, Iowa; P. E. Blackerby, M.D., Louisville, Kentucky; James R. Bloss, M.D., Huntington, West Virginia; F. F. Borzell, M.D., Philadelphia, Pennsylvania; John S. Bouslog, M.D., Denver, Colorado; James Boyle, Washington, D. C.; A. A. Brindley, M.D., Toledo, Ohio; W. R. Brooksher, M.D., Fort Smith, Arkansas; John W. Brownlee, Rutland, Vermont; A. S. Brunk, M.D., Detroit, Michigan; A. S. Bristow, M.D., Princeton, Missouri; Louis A. Buie, M.D., Rochester, Minnesota; W. A. Bunten, M.D., Cheyenne, Wyoming; Alex M. Burgess, M.D., Providence, Rhode Island; C. Charles Burlingame, M.D., Hartford, Connecticut; Wm. J. Burns, Lansing, Michigan; W. L. Burnap, M.D., Fergus Falls, Minnesota; John F. Burton, M.D., Oklahoma City, Oklahoma.

Mac F. Cahal, Chicago, Illinois; C. L. Candler, M.D., Detroit, Michigan; Donald Cass, M.D., Los Angeles, California; Ralph H. Chaney, M.D., Augusta,

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Georgia; W. C. Chaney, M.D., Memphis, Tennessee; C. H. Chapman, Detroit, Michigan; Peter P. Chase, M.D., Providence, Rhode Island; L. G. Christian, M.D., Lansing, Michigan; John W. Cline, M.D., San Francisco, California; E. P. Coleman, M.D., Canton, Illinois; Benjamin F. Cook, M.D., Rutland, Vermont; George Cooley, Toledo, Ohio; Donn R. Court, Chicago, Illinois; F. S. Crockett, M.D., Lafayette, Indiana; C. H. Crownhart, Madison, Wisconsin; F. R. Croson, M.D., Topeka, Kansas; Robert Cunningham, Chicago, Illinois.

A. Ray Dawson, Chicago, Illinois; William DeKleine, M.D., Lansing, Michigan; Carleton Dean, M.D., Lansing, Michigan; W. F. Donaldson, M.D., Pittsburgh, Pennsylvania; L. F. Donohoe, M.D., Bayonne, New Jersey; Carl B. Drake, M.D., St. Paul, Minnesota; Warren F. Draper, M.D., Washington, D. C.

Oliver E. Ebel, Topeka, Kansas; Miss A. V. Edwards, Richmond, Virginia; F. E. Elliott, M.D., Brooklyn, New York; M. E. S. Elwood, Philadelphia, Pennsylvania; William L. Estes, Jr., M.D., Bethlehem, Pennsylvania.

John E. Farrell, Providence, Rhode Island; Pauline Farrell, Topeka, Kansas; George P. Farrell, New York, New York; Ralph A. Fenton, M.D., Portland, Oregon; F. L. Feierabend, M.D., Kansas City, Missouri; Robert E. Fitzgerald, M.D., Wauwatosa, Wisconsin; John H. Fitzgibbon, M.D., Portland, Oregon; L. Fernald Foster, M.D., Bay City, Michigan; Margaret R. Foster, Topeka, Kansas.

Leroy U. Gardner, M.D., Saranac Lake, New York; S. E. Gavin, M.D., Fond du Lac, Wisconsin; Carl H. Gellenthien, M.D., Valmora, New Mexico; Cole B. Gibson, M.D., Meridian, Connecticut; Philip K. Gilman, M.D., San Anselmo, Calif.; Lowell S. Goin, M.D., Los Angeles, Calif.; Richard H. Graham, Oklahoma City, Okla.; T. K. Gruber, M.D., Eloise, Michigan.

W. B. Harm, M.D., Detroit, Michigan; William Hale, M.D., Utica, New York; J. D. Hamer, M.D., Phoenix, Arizona; B. Wallace Hamilton, M.D., New York City, New York; C. M. Hamilton, Nashville, Tennessee; William M. Hardy, M.D., Nashville, Tennessee; J. F. Harrig, M.D., Kansas City, Kansas; Wilfrid Haughey, M.D., Battle Creek, Michigan; Barney J. Hein, M.D., Toledo, Ohio; T. A. Hendricks, Chicago, Illinois; Joseph H. Howard, M.D., Bridgeport, Connecticut; John F. Hunt, Chicago, Illinois; John Hunton, San Francisco, Calif.; Louis J. Hirschman, M.D., Detroit, Michigan; Daniel J. Hurley, Eureka, Nevada; Raymond Hussey, M.D., Detroit, Michigan; William A. Hyland, M.D., Grand Rapids, Michigan.

Earle G. Johnson, M.D., Grand Island, Nebraska; H. M. Jahr, M.D., Omaha, Nebraska; Edward Jelks, M.D., Jacksonville, Florida; George P. Johnston, M.D., Cheyenne, Wyoming; Wingate M. Johnson, M.D., Winston-Salem, N. C.

Jay C. Ketchum, Detroit 26, Michigan; C. R. Keyport, M.D., Grayling, Michigan; E. M. Kinger, Des Moines, Iowa; H. L. Kretschmer, M.D., Chicago, Illinois.

George Larson, Chicago, Illinois; Joseph S. Lawrence, M.D., Washington, D. C.; P. L. Ledwidge, M.D., Detroit, Michigan; Adam P. Leighton, M.D., Portland, Maine; T. K. Lewis, M.D., Camden, New Jersey; Charles Lively, Charleston, W. Virginia; J. F. Londrigan, M.D., Hoboken, New Jersey; J. B. Lukins, M.D., Louisville, Kentucky.

George W. Kosmak, M.D., New York, New York.

H. Gordon MacLean, M.D., Oakland, Calif.; C. H. McCaskey, M.D., Indianapolis, Indiana; Sam J. McClendon, M.D., San Diego, Calif.; Mrs. S. J. McClendon, San Diego, Calif.; Mary L. McCord, Des Moines, Iowa; E. J. McCormick, M.D., Toledo, Ohio; L. S. McKittrick, M.D., Boston, Massachusetts; Charles McMartin, M.D., Omaha, Nebraska; James R. McVay, M.D., Kansas City, Missouri; John R Mannix, Chicago, Illinois; K. E. Markuson, M.D., E. Lansing, Michigan; Col. Walter B. Martin, MC, Norfolk, Virginia; M. L. Meadors, Florence, So. Carolina; J. R. Miller, M.D., Hartford, Connecticut; O. O. Miller, M.D., Louisville, Kentucky; W. M. Mills, M.D., Topeka, Kansas; P. R. Minahan, M.D., Green Bay, Wisconsin; Josiah J. Moore, M.D., Chicago, Illinois; L. J. Moorman, M.D., Oklahoma City, Okla.; R. S. Morrish, M.D., Flint, Michigan; Frank R. Mount, M.D., Portland, Oregon; H. B. Mulholland, M.D., Charlottesville, Va.; T. P. Murdock, M.D., Meriden, Connecticut; Bradford Murphey, M.D., Denver, Colorado; Dwight Murray, M.D., Napa, California.

Cleon A. Nafe, M.D., Indianapolis, Indiana; J. Louis Neff, New York, New York; C. S. Nelson, Columbus, Ohio; L. S. Nelson, M.D., Salina, Kansas; Carl M. Neupert, M.D., Madison, Wisconsin; R. L. Novy, M.D., Detroit, Michigan.

E. H. O'Conner, Chicago, Illinois; T. R. O'Brien, St. Louis, Missouri; A. J. Offerman, M.D., Omaha, Nebraska; J. D. Osborn, M.D., Frederick, Oklahoma; O. B. Owens, Alexandria, Louisiana.

C. L. Palmer, M.D., Pittsburgh, Pennsylvania; Robert L. Parker, M.D., Des Moines, Iowa; Homer L. Pearson, M.D., Miami, Florida; J. H. A. Peck, M.D., St. Francis, Kansas; Robert A. Peers, M.D., Colfax, California; Grover C. Penberthy, M.D., Detroit, Michigan; Lester H. Perry, Harrisburg, Pennsylvania; C. M. Peterson, M.D., Chicago, Illinois; Arthur R. Porter, Jr., M.D., Memphis, Tennessee; Julian P. Price, M.D., Florence, South Carolina.

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(Continued on Page 415)

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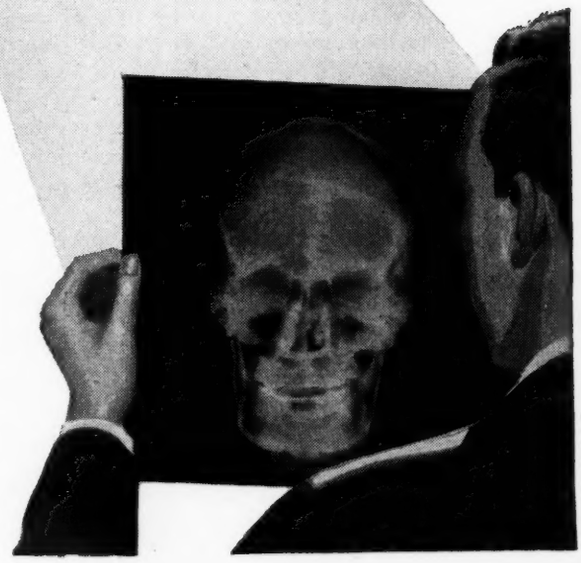

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Program of Health Legislation Beneficial to the People

WHEREAS, It is the earnest desire of the medical profession of this country to provide better health care for the American people and improve health facilities and standards, therefore be it

RESOLVED, That the following principles for a health legislation program be adopted:

1. Establishment in the President's Cabinet of a Secretary of Public Health and Medical Welfare, who shall be selected from the ranks of actively practicing physicians, and under whose jurisdiction every federal bureau and office, whose duties are related to health and medical welfare, shall be grouped.

2. Encouragement of medical and other scientific research and study for the continuous improvement of medical care by government grants-in-aid.

3. Provide federal or state loans, or guarantees of private loans, for the expansion of hospital and educational facilities, the operation of same to be entirely supervised, controlled, and carried on by those who own such facilities and by the medical profession.

4. (a) Establish state-wide voluntary non-profit health care programs, in every state, based on the free choice of purveyors of health care; such programs shall act as a service plan to all in groups classified as within a special income level as determined by the plan in each state or regional unit; as an indemnity plan for those classified as above that income level by each state or regional unit; as a service plan to the indigent and semi-indigent by contractual arrangement for payment of charges from county, state or federal funds; as a service plan for all other governmental categories eligible for health care; as a service plan for all physicians' services to veterans of the armed forces for all illnesses or disabilities eligible under the law.
   (b) Any further federal or state programs for expansion of medical service to be developed within the structure of the above-described program.
   (c) National co-operation with the proposed plans of Major General Paul R. Hawley of the Veterans Administration in the therapeutic administrations to veterans for service-connected disabilities. Also for the development of veteran facilities as teaching hospitals under the medical direction of civilian consultants in the respective specialized medical departments.
   (d) All state-wide medical care programs on either a service or indemnity care basis shall be incorporated under special state-enabling acts or by already existing state statutes relating to non-profit producers' co-operatives. This will provide for either a prepayment or a reimbursement contractual service.
   (e) Group co-operation and reciprocity, on a national level, by all voluntary state medical and hospital care (Blue Cross) programs, should be accomplished.

5. We suggest establishment in communities where feasible of a public information and educational service adequately financed, to advise all the people with respect to proven measures to prevent illness, hygienic and sanitary measures, and where to go to seek help when ill or injured.

6. The function of government, federal and state, should be to encourage and assist, rather than to compete with, reputable voluntary health insurance plans, and be it further

RESOLVED, That every state medical society be invited to study, adopt and activate these principles on the state level, and that they be submitted to the AMA Council on Medical Service and Public Relations for immediate consideration as a pattern for a national health program.

Adopted by Conference of Presidents and other Officers of State Medical Societies, December 2, 1945; referred by 1945 AMA House of Delegates to the AMA Council on Medical Service and Public Relations, December 5, 1945.

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MSMS Annual County Secretaries Conference

January 20, 1946

A total of one-hundred fifty-seven attended the Annual County Secretaries Conference of the Michigan State Medical Society held at the Wardell-Sheraton Hotel on January 20, 1946. Unanimous was the praise for an intensely interesting and enlightening program over which G. B. Saltonstall, M. D., Charlevoix, presided.

The meeting opened with a "Progress Report on Michigan Medical Service" presented by R. L. Novy, M. D., Detroit, President of MMS. This was followed by a trip from the Wardell-Sheraton Hotel to Michigan Medical Service and a tour of the headquarters of Michigan's voluntary group medical care plan, in operation.

Colonel J. C. Harding, M.C., representative of Major General Paul R. Hawley, M.C., of the Veterans Administration, Washington, D. C., spoke on "The Program of Medical Care of the U. S. Veterans Administration."

L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, presented facts on the "Uniform Fee Schedule for Governmental Agencies."

E. I. Carr, M.D., Lansing, President of the Michigan Foundation for Medical and Health Education, Inc., spoke on the "Aims and Purposes of the Health Foundation."

E. J. McCormick, M.D., Toledo, Chairman of the AMA Council on Medical Service and Public Relations, spoke on "Medical Public Relations" and gave an enlightening account of the progress and aims of his Council.

The round-table discussion was led by S. W. Insley, M.D., Detroit, President of the Wayne County Medical Society.

Dr. Saltonstall was re-elected as Chairman of the Conference for the ensuing year, by unanimous vote.

The thirty-three County Secretaries present at the Conference were:

U. M. Adams, M.D., Cass; J. K. Altland, M.D., Barry; M. P. Bates, M.D., Hillsdale; Harry Berman, M. D., Tuscola; E. W. Blanchard, M.D., Sanilac; J. Russell Brink, M.D., Kent; A. L. Callery, M.D., St. Clair; E. S. Carr, M.D., Chippewa-Mackinac; Ray M. Duffy, M.D., Livingston; M. R. French, M.D., Van Buren; H. H. Gay, M.D., Midland; J. Bates Henderson, M.D., Huron; L. Dell Henry, M.D., Washtenaw; T. Y. Ho, M.D., Clinton; K. H. Johnson, M.D., Ingham; W. S. Jones, M.D., Menominee; G. J. Kemme, M.D., Ottawa; Felix J. Kemp, M.D., Oakland; R. Bruce Macduff, M.D., Genesee; J. E. Mahan, M.D., Allegan; Don Marshall, M.D., Kalamazoo; W. S. Martin, M.D., Mason; J. J. McCann, M.D., Ionia-Montcalm; H. R. Moore, M.D., Newaygo; A. P. Murphy, M.D., Saginaw; E. S. Parmenter, M.D., Alpena; G. T. Patrick, M.D., Calhoun; H. W. Porter, M.D., Jackson; G. B. Saltonstall, M.D., Northern Michigan; L. G. Sevener, M.D., Eaton; Stanley A. Stealy, M.D., North Central Counties; Gordon Tornberg, M.D., Wexford; D. Bruce Wiley, M.D., Macomb. Executive Secretaries Sara M. Burgess, Genesee; and Else Kolhede, Wayne.

Presidents of County Medical Societies who attended were:

A. B. Bower, M.D., Macomb; D. R. Brasie, M.D., Genesee; C. G. Darling, Jr., M.D., Oakland; W. L. Howard, M.D., Calhoun; S. W. Insley, M.D., Wayne; David M. Kane, M.D., St. Joseph; C. L. Weston, M.D., Shiawassee; J. J. Woods, M.D., Washtenaw; H. B. Zemmer, M.D., Lapeer.

Representatives of the Woman's Auxiliary, totalling twenty, were present:

Mrs. R. H. Alter, Jackson; Mrs. T. G. Amos, Wayne; Mrs. Chas. J. Barone, Wayne; Mrs. F. G. Buesser, Wayne; Mrs. A. L. Callery, St. Clair; Mrs. Lloyd A. Campbell, Saginaw; Mrs. Lloyd C. Harvie, Saginaw; Mrs. Robert Jaenichen, Saginaw; Mrs. D. M. Kane, St. Joseph; Mrs. Wm. B. Kerr, Saginaw; Mrs. R. Bruce Macduff, Genesee; Mrs. W. MacKersie, Wayne; Mrs. Don Marshall, Kalamazoo; Mrs. G. L. McClellan, Wayne; Mrs. Harold A. Miller, Ingham; Mrs. R. S. Morrish, Genesee; Mrs. R. L. Novy, Wayne; Mrs. A. C. Pfeifer, Genesee; Mrs. R. C. Pochert, Shiawassee; Mrs. L. Paul Sonda, Wayne; Mrs. O. D. Stryker, Newaygo; Mrs. Wm. L. Sherman, Wayne.

MSMS Officers who attended included:

President, R. S. Morrish, M.D., Secretary, L. Fernald Foster, M.D., Treasurer, A. S. Brunk, M.D., Speaker, P. L. Ledwidge, M.D., and Councilors, W. E. Barstow, M.D., O. O. Beck, M.D., T. E. DeGurse, M.D., Fred Drummond, M.D., W. H. Huron, M.D., R. C. Pochert, M. D., E. F. Sladek, M.D., O. D. Stryker, M.D., C. E. Umphrey, M.D., E. R. Witwer, M.D., and Past Presidents, L. J. Hirschman, M.D., and J. M. Robb, M.D., both of Detroit.

Editors present were:

Wilfrid Haughey, M.D., JOURNAL of the Michigan State Medical Society; J. S. Lambie, M.D., Oakland County Bulletin; J. J. Lightbody, M.D., Detroit Medical News; A. C. Pfeifer, M.D., The Bulletin, Genesee County; and Associate Editor John M. Markley, M.D., Oakland County Bulletin.

Others who attended included:

V. C. Abbott, M.D., Pontiac; Major A. D. Alguire, Lansing; Percy C. Angove, Detroit; Chas. J. Barone, M.D., Highland Park; Joseph J. Bauser, Detroit; H. M. Best, M.D., Lapeer; R. J. Borer, M.D., Toledo, Ohio; W. H. Boughner, M.D., Algonac; H. W. Brenneman, Lansing; Thelma Brewington, Lansing; C. L. Candler, M.D.,

(Continued on Page 380)

The Grand Rapids Press Comments on Michigan Medical Service

State Medicine Unnecessary

Phenomenal growth of the Michigan Medical Service, as reported to the state public health conference now in session in Grand Rapids, shows the great good that can be accomplished under an efficiently administered voluntary health insurance plan that sells itself to the public on its own merits. The response in Michigan proves conclusively that, given an opportunity to provide for their own medical needs on a thrifty small-payment plan, individuals and heads of families will virtually "eat it up." And state after state, where these "blue cross" plans are expanding, is adding new evidence of their worth.

It is axiomatic that social security never goes backward. In our humanitarian society, public opinion undoubtedly favors its gradual extension on a sound basis. What form that extension is to take is a decision this country will have to make when congress comes to grips with the Murray-Wagner-Dingell social security bill. Included in the "cradle-to-grave" security provided in that bill is a proposal for state medicine that would cost the taxpayers an estimated $1,750,000,000 annually. The fate of this measure will decide whether we are to have government-sponsored health insurance with its tremendous administrative problems and bureaucratic evils or whether we are to preserve the American system of individual responsibility and self-reliance.

It has perhaps escaped the notice of the average American that the United States government has for a generation conducted an experiment in state medicine through its care of ill or disabled veterans of the first World War. Nominally there have been some restrictions based on the veteran's condition and his ability to pay, but in practice the government pays. Recent investigations by congressional committees and servicemen's organizations have revealed serious abuses. Medical service in the veterans' hospitals has been rated "poor to average." It has been shown that the government service has not attracted a high quality of professional talent; has not encouraged experimental research and scientific progress in new methods of treatment; and in general has been inefficiently operated. Sweeping reforms are demanded as the government prepares to extend the service to veterans of this war. Surely that object lesson should stand as a warning against the extension of government-paid medical service to the families of America.

Advocates of state medicine challenge its opponents to produce an alternative that will make competent medical treatment available to the masses. Obviously, as the old saying goes, "you cannot beat something with nothing." But you can beat something with something better—and the Michigan Medical Service, which offers its subscribers an economical group plan for paying for their own medical care and the opportunity to choose their own physician instead of taking whatever the government would provide under the dole—seems to point the way to that "something better." Obviously the coverage in this state would not have increased 800 per cent in five years if satisfied patients had not recommended the service to their friends and fellow workers.

Michigan can well be proud of the fact that it was a pioneer among the states in the setting up of a medical service plan and that no other state has such extensive coverage. The success of the experiment is something to cheer about. Here is concrete proof that state medicine a la Murray-Wagner-Dingell is as unnecessary as it would be dangerous to the American philosophy of the individual's relation to his government.

As Mr. Ketchum, executive of the Michigan Medical Service, pointed out in addressing the public health group, the American people should understand that any system of government health insurance, once undertaken, would inevitably be permanent. The opportunities it would furnish for political patronage would be so enormous that the politicians could never be persuaded to give it up. The country would be saddled with another sprawling bureaucracy that would top anything we have yet experienced. But if the public demand that good medical care be made available to everyone becomes insistent enough, government will step in to provide it unless private initiative does the job through voluntary methods.

Michigan, by trying the voluntary plan and

(Continued on Page 347)

Veterans Administration Contract With Michigan Medical Service

So many requests have been received for a copy of the salient points of the contract of December 27, 1945, for "home-town medical care of veterans" in Michigan, that the important paragraphs of this document between the Veterans Administration and Michigan Medical Service are printed, as follows:

The Michigan Medical Service agrees to make available during the fiscal year ending June 30, 1946, all services outlined below in accordance with the terms and conditions hereinafter prescribed:

(1) The Michigan Medical Service will arrange, through physicians registered with it for the rendition of the medical services covered by this agreement, for examinations, treatments and counsel in such cases as may be authorized by the Veterans Administration, Michigan Medical Service reserving the right, however, to decline any particular case.

(2) The Veterans Administration will authorize examinations, treatments and counsel. Authorizations for such services will be issued to the Michigan Medical Service; the Michigan Medical Service will advise the veteran to report to a physician of the veteran's selection in his community, such selection to be limited to those physicians registered with the Michigan Medical Service for the rendition of services under this agreement.

(3) The Michigan Medical Service will be responsible to see that reports required by the Veterans Administration are in proper form and that proper records are maintained which will be available for review by the Veterans Administration at any time. The Veterans Administration will review reports of services and will return to Michigan Medical Service for further action, without additional cost to the Veterans Administration, those which do not meet the requirements of the Veterans Administration.

(4) Fees for medical services will be in accordance with the fee schedule, which is attached hereto and made a part of this contract. It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by Michigan Medical Service to the Veterans Administration for determination of appropriate fee.

(5) The Michigan Medical Service will make payment to the individual physicians for services rendered on all cases in which authorizations have been issued and will in turn bill the Veterans Administration at the end of each month. Veterans Administration will remit in accordance with such bill within a reasonable time after receipt thereof.

(6) The Michigan Medical Service contemplates that the performance of this contract will be without profit to it and if operating results are at variance with this intention revisions will be proposed to produce such a non-profit operation.

The Michigan Medical Service warrants that the rates charged herein are not in excess of the rates charged other persons, who are not Veterans Administration beneficiaries for the same services.

It is impossible to determine the exact or estimated amount which will be expended under this contract. However, it is understood that upon acceptance of this proposal, the Veterans Administration will issue authorizations for such services as are necessary and Michigan Medical Service will carry out its undertaking hereunder.

This contract shall become effective as of January 15, 1946, and may be terminated by either party by giving thirty (30) days written notice to that effect.

This contract, if mutually satisfactory, may be renewed indefinitely for periods of one (1) year each, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal.

NOTICE TO BIDDERS—Prices bid should include any applicable federal excise taxes, as the United States is not exempt from payments of such taxes.

No member of or delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this contract or to any benefit that may arise therefrom unless it be made with a corporation for its general benefit.

Michigan Medical Service agrees that in performing this contract it will not discriminate against any employe or applicant for employment because of race, creed, color or national origin, and that it will include a similar provision in all of its subcontracts.

MICHIGAN MEDICAL SERVICE

By:.....

.....

(Title)

APPROVED AND ACCEPTED.
VETERANS ADMINISTRATION

.....

R. C. KIDD

Director of Supplies

.....

(If bidder is a corporation, Form 1264 must be filled out and attached to the contract)

(The part of this contract from "Notice to bidders" is standard form in all contracts to which the government is a part.—Editor).

Medical Veterans' Readjustment

HOME-TOWN TREATMENT

The *New York Times* for January 6, 1946, published an article by Howard A. Rusk, M.D., calling attention to the test plan in Michigan. We quote freely from the article. Its exposition of the problem of the veteran is excellent.

The medical services of the Veterans Administration took a long step in demonstrating how this can be achieved this past week when they announced an arrangement under which Michigan war veterans may receive "home-town" medical care by doctors of their own choice at Government expense.

This plan is frankly a trial run, but if it works satisfactorily, officials of the Veterans have said that it would be extended to other States.

Michigan was chosen for the test because of the splendid record and co-operation of the Michigan Medical Service. This organization, operated by the Michigan State Medical Society, has had more than five years' experience and now has about 875,000 subscribers to a voluntary health insurance plan with about 3,000 doctors participating in the service.

The Veterans Administration has not insured the individual veteran as the civilian subscriber has been covered in the Michigan plan, but is purchasing the service from the Michigan Medical Service, which, in turn, will pay the doctor who gives the professional care.

The plan does not include hospitalization at present, but this is expected to be the next step. When this is done the veteran with a service-connected disability will receive both outpatient care and hospitalization in his own community, provided such hospitals belong to the approved Statewide participating group.

For many years Veterans Administration hospitals admitted only men with disabilities growing out of military service. But in the Nineteen Thirties, with a number of beds unoccupied, the law was amended to permit care of veterans with sickness and disabilities not caused directly by military service, if bed space was available and the veteran signed a statement to the effect that he was unable to pay for private medical care.

The primary purpose of the new Michigan plan is to ease that critical pressure on Veterans Administration hospitals, for under the new system many veterans with service-connected disabilities may be treated in their own home towns, thus releasing critical beds in Veterans Administration hospitals and making available the necessary room for the expanding medical and rehabilitation programs.

Equally important and perhaps even more far reaching in final implications is the effect of "home-town" treatment in reducing the period of hospitalization. Veterans now are frequently kept in the hospital until total recovery to permit observation during convalescence.

It may well be that the Michigan experiment will revise the whole operating philosophy of the Veteran Administration's medical service. If it is successful, each veteran might receive a comprehensive medical insurance policy which would take care of his ordinary medical needs. The present Veterans Administration hospitals then could be used for domicilary and highly specialized medical care.

This is a real step in the right direction toward reintegration of the veteran into his community, a move toward a realization by every man who has experienced military service that he is a citizen first and veteran second.

HOME-TOWN HOSPITAL SERVICE FOR VETERANS

Michigan's pioneering program providing for "home-town" medical and hospital care of veterans with service-connected disabilities will be in operation by about May 1, was announced by W. H. Lichty, executive director of Michigan Hospital Service, the Blue Cross Plan.

The new program, designed to help relieve the great demands upon the regular Veterans Hospitals, will authorize veterans to go to any registered doctor or hospital when care or treatment in a Veterans' institution is not "feasibly available."

Upon the veteran's application for service-connected treatment or care, the Veterans Administration will determine whether the case is to be handled in the Veterans facility or whether the veteran is to be authorized to receive service from a local doctor or hospital.

It is expected that thousands of veterans will be able to receive needed services from the hospitals and doctors of their own choice through the new program.

The contract providing for local hospital care was signed between the Veterans Administration and Michigan Hospital Service, January 31, 1946. It follows by a month the signing of a contract between the Veterans Administration and Michigan Medical Service, companion organization to Michigan Hospital Service.

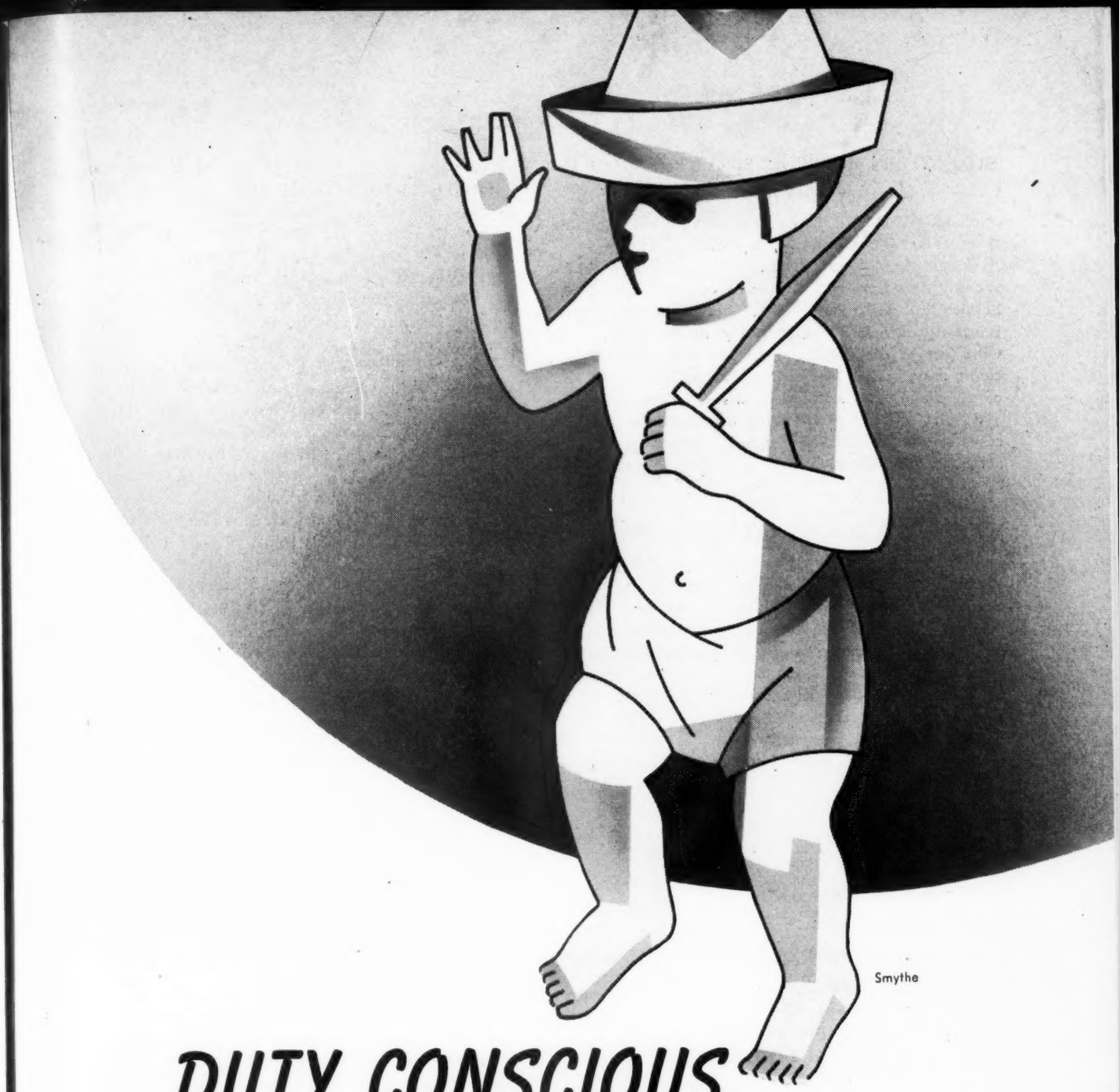
"We will not know which hospitals will be participating in this program or how many beds they will be able to make available until we have contacted all the hospitals individually," Lichty explained.

"On the basis of our advance contacts with the hospitals, however, we believe that practically all of them plan to register to provide service to the veterans. We hope that we shall have a fairly complete list by May 1."

About half of Michigan's practicing physicians already have registered to provide medical services to the veterans, and hundreds of additional registrations are coming in each week, according to J. C. Ketchum, executive vice president of Michigan Medical Service.

Under the new program when it goes into operation, veterans with service-connected disabilities will make

(Continued on Page 302)



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HOME TOWN HOSPITAL SERVICE

(Continued from Page 300)

application for care to the nearest Veterans Administration contact representative, as usual.

If care by a local doctor or hospital is authorized, the authorization will be issued to Michigan Hospital Service and Michigan Medical Service, which organizations will furnish it immediately to the veteran along with lists of the registered doctors and hospitals in his community. The veteran then can make his own choice of the doctor and hospital he wishes to use.

Special procedures are being developed for emergency cases so that medical or hospital services can be made available immediately.

WAYNE UNIVERSITY VETERAN COURSES

Many postgraduate courses are now in process at Wayne University, for the readjustment of veterans, and available to them only. These courses began December 31, 1945, and are continuing for ten weeks. The fee is nominal. Regional Dissection; Survey of Pharmacology; Principles of Therapeutics; Review of Physiological Chemistry; Ward Rounds and conferences (limited to four) on Hematology; Psychiatry (limited to 12); Basic Ophthalmology (limited to 12). There were short courses now finished (four weeks) Clinic and Conference on Dermatology; Ward Rounds and Conferences on Internal Medicine.

Many courses are available during the quarter beginning December 31, 1945. There are continuation courses designed for practitioners and veterans. They are approved for residency training by the Committee on Medical Education of the AMA. Anatomy; Advanced Dissection; Evolution of the Human Body; Advanced Histology; Endocrinology; Problems in Neurology. Pharmacology: Physical Medicine; Seminar in Pharmacology. Bacteriology: Clinical Pathology; Immunology and Virology. Physiological Chemistry: Nutrition; Carbohydrate Metabolism; Seminar in Physiological Chemistry. Pathology: Pathology of Tuberculosis; Neoplasms; Heart. Internal Medicine: Medical Pathological Conferences; Diagnostic Conferences; Electrocardiology; Therapeutic Conferences; Hematologic Conferences; Gastro-enterology; Medical X-ray Conferences; Neurological Conferences; Psychosomatic Clinic. Dermatology: Dermatopathology; Conference on Venereal Diseases; Seminar in Dermatology.

This postgraduate program includes work leading to a Master's Degree in all of the Medical Specialties. There is also a Basic Science work for hospitals maintaining residency programs, and a number of hospitals not associated with medical schools are enrolled. The faculty welcome ex-servicemen to help develop their refresher or postgraduate plans.

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Political Medicine

NATIONAL FOUNDATION TO COMBAT ARTHRITIS

We have received a news release from a New York office headed "President Truman Heads New National Foundation to Combat Arthritis." A national campaign is being inaugurated to raise $2,500,000 for the establishment of a research foundation with main buildings to be located at Hot Springs National Park. In the names of sponsors are only two doctors of medicine, Thomas Parran, Surgeon General of the U. S. Public Health Service, and Morris Fishbein.

This is a worthy cause, and should be encouraged, but the honorary sponsor and the *first* medical name on the list do not lend to the belief that the best of scientific attainments will always be the uppermost function. Both of these gentlemen are advocating in every manner and at every opportunity the socializing of medicine. One misquotes selective service figures to substantiate the plan of national compulsory health insurance to which he has allowed his name to be attached, and the other has attempted to compel his under officers to submit to a muzzle when discussing the subject of political or socialized medicine.

FACTS AND FANCIES REGARDING 30 PER CENT OF DRAFT REJECTIONS

President Truman, in his address to the 79th Congress, November 19, 1945, gave as his first reason for proposing compulsory health insurance the fact that the draft rejected 30 per cent of those examined on account of physical defects. He said:

"The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our Nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

"As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 per cent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 per cent for registrants between the ages of thirty-four and thirty-seven.

"In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

"Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

"These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives."

An analysis of the so-called 5,000,000 4-F's, or 30 per cent who were rejected, for military defects, was made by Lowell S. Goin, M.D., retiring president of the California Medical Association and printed in *California and Western Medicine,* May 1945:

"Since the five million 4F's are so frequently invoked, and since it is at first glance so shocking a figure, let us examine it in some detail. One difficulty with the argument is that intellectually it is not very honest. In Senator Pepper's interim report the figure is announced on page one not as five million, but as four-and-one-half million, but on page three of the same report the graph discloses the true figure to be 4,217,000. An error of 13.5 per cent can scarcely be considered as insignificant.

"Of the total number rejected 444,000 were rejected as manifestly disqualified, that is to say the totally blind, the totally deaf, the deaf-mutes, the legless, the armless and so forth. It seems perfectly obvious that no program of medical care could have influenced this figure.

"701,700 were rejected for mental disease. Again I don't know of a program of medical care which would have prevented mental disease in these unfortunate people.

"582,000 were rejected for mental deficiency, that is to say, that they were the imbeciles, the idiots and the morons. The most casual knowledge of eugenics would persuade anyone that this group does not constitute a medical problem, and these three groups together reach the large total of 1,727,600.

"When these have been excluded there remain 2,426,500 or somewhat less than half of the originally claimed five-million.

"Of this group 320,000 were rejected for muscular-skeletal defects, that is to say the clubfoot, the paralytic, the withered arm, the congenitally dislocated hip and so forth. Again I wonder what program of medical care might have made this group fit for military service.

"280,000 were rejected for syphilis. The statute books are already loaded with laws regarding syphilis. There is probably not a community in the United States in which a person afflicted with this disease cannot secure treatment from the Department of Public Health. How, then, would compulsory health insurance have eliminated this group?

"220,000 were rejected for hernia. Hernia is a congenital defect and if a person is born with a defective inguinal or femoral canal he is likely to have a hernia and medical care has nothing whatever to do with the occurrence of hernia.

"160,000 were rejected for 'eyes.' Since eyes would seem to be useful adjuncts to men who were to be soldiers or sailors I presume that this means defective vision. If one is born with an eyeball too long or too short or one which is not a globe one will either wear glasses or not see very well and medical care has nothing whatever to do with it.

"Thus about one million more have been eliminated and the number of rejections on a basis of lack of medical care is about 1,500,000. Whether any program of

(Continued on Page 306)

War Medicine

ARMY NEUROPATHOLOGIST'S REPORT ON EXAMINATION OF DR. ROBERT LEY'S BRAIN

The brain of Dr. Robert Ley, Nazi leader, which was shipped by air to the United States in November of last year for gross examination and microscopic study by Army pathologists shows "a long-standing degenerative process of the frontal lobes."

Degeneration in the brain of Dr. Ley, who hanged himself to avoid trial as a war criminal, was sufficient to account for the unusual behavior of the former German labor leader.

Reports on the results of the neuropathological study of the brain, which was made at the Army Institute of Pathology under the direction of Colonel J. E. Ash, stated that photographs of the brain show considerable thickening of the brain covering over the frontal lobes of both sides. The underlying convolutions as well as some of the blood vessels are hidden from view by this thickening. However, the rest of the brain has a normal appearance, in that it is delicate and transparent.

Slight atrophy is indicated by the prominent condition of the grooves between the convolutions of the frontal lobes, and examination of the frontal lobes under the microscope disclosed a long-standing degenerative process, which in medical parlance is referred to as a "chronic encephalopathy."

This disease process cannot be ascribed to the airplane accident Dr. Ley suffered in 1917, because the damage is so symmetrical, according to Army pathologists. They also added that there is no evidence of pre-existing meninigitis.

Dr. Ley's type of degeneration, the report pointed out, is sometimes seen in those addicted to alcohol, but proof that alcohol is in itself a causative factor is completely lacking. The degeneration is of sufficient duration and degree to have impaired Dr. Ley's mental and emotional faculties and could well account for his alleged aberrations in conducts and feelings, since normally the frontal lobes are requisite for complex types of thinking and for a proper development of the "social sense" and since they exercise a restraint on emotional impulses, the report explained.

CIVILIAN INSTITUTIONS WILL PROFIT FROM ARMY PSYCHIATRIC EXPERIENCES

By applying the psychiatric lessons learned in recent years, the industrial, educational and criminal institutions of the country and society in general can derive tremendous benefits, according to Brigadier General William C. Menninger.

In order to capitalize on these advances, there must be a wider dissemination of this knowledge among the practicing physicians in this country and more workers must be attracted to the field of psychiatry. Major changes must also be made in medical education if full results are to be attained, General Menninger added.

The marked strides made in neuropsychiatry, which represent one of the major achievements of the Medical Department, were made possible through the skill and knowledge of many of the nation's outstanding psychiatrists, who were marshaled together by the Surgeon General's Office to collaborate in the treatment and prevention of neuropsychiatric cases at a time when there were more cases of this type than medical science had ever dealt with before.

The size of the problem is indicated in the fact that 314,500 men had been discharged by July 1, 1945, for neuropsychiatric causes. This figure represents 43 per cent of the soldiers discharged for medical reasons. In addition, there were 130,000 more men discharged because of personality defects which made them unsuitable for the Army. The picture becomes even darker, considering that out of 4,650,000 men rejected for all causes, 1,825,000, or 39 per cent were rejected for some type of personality disorder.

General Menninger said that a majority of these discharged soldiers will be able to make a normal adjustment in civilian life. Surveys have shown that most of them are able to adapt themselves to their respective communities and are able to hold down jobs again Satisfaction in work and play, security and understanding on the part of family and friends provide the best medicine for these veterans.

Through its wide experience with neuropsychiatric cases in this war, the Army developed methods of treatment which proved effective in caring for the soldiers suffering from mental and nervous disorders.

The stress of combat produced a large number of what the Army calls "combat exhaustion cases." From 30 to 40 per cent of these soldiers were salvaged by psychiatric treatment in the first two days close to the front lines, while an additional 20 per cent were made fit for duty in from five to eight days at an improvised unit called the exhaustion center.

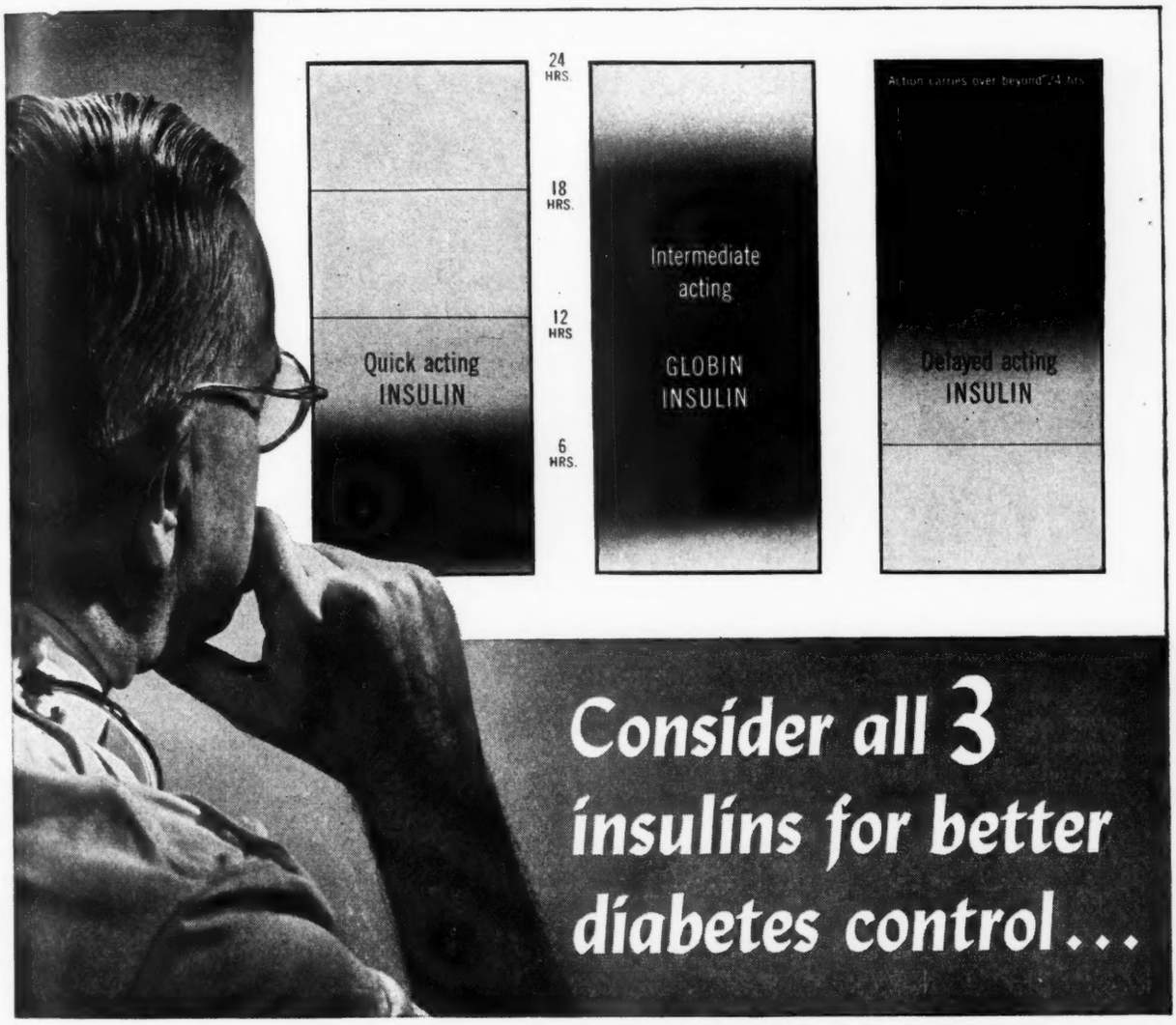
POLITICAL MEDICINE

(Continued from Page 304)

medical care would have materially reduced this number is problematical.

"If the proponents wish to rest their case upon the need shown here (and they have made a great deal of it), I am content."

We might be impressed by some of the arguments from those who are trying to socialize medicine, if those arguments were honest, but if they are so distorted as these facts we wonder whether their basic thinking is not fully as distorted.



THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—'Wellcome' Globin Insulin with Zinc—is intermediate.

Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of 'Wellcome' Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all *three* insulin types.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered

'WELLCOME' *Globin* *Insulin* WITH ZINC

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BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

The Doctor's Hobby

MODERN WORKSHOPS

By KELCY KERN

The architectural profession recently announced that over half of all new postwar homes would either be equipped with modern workshops or provisions would be made in the plans for their installations at a later date. There are several reasons for this trend of millions of

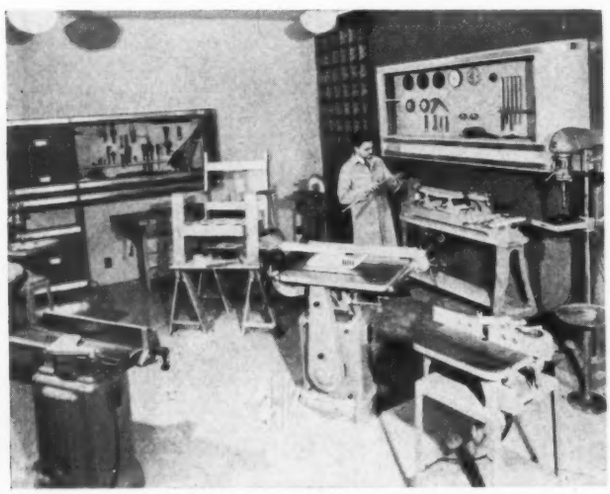

Fig. 1. A modern workshop.

our people of both sexes, old and young, toward the use of tools and machinery in the home. One is, that millions learned to use tools and machinery in wartime trade schools, secondary schools, war plants and in the armed forces, and a large percentage of them will now continue working in wood, plastics and metals as a hobby.

In this hobby many in the medical profession are finding an ideal pastime and one which, at the same time, can be made really productive. The internist today working under constant pressure and tension needs a form of relaxation which will interest and amuse and, at the same time, provide an outlet for nerves kept on edge by long hours of arduous work and responsibility. Stated Dr. A. Stanley Kaye, 751 Gerard Avenue, Bronx, N. Y., whose home workshop has attracted widespread comment in the press:

"Having a home workshop is marvelous for the development of personal morale, for the occupation it provides for the mind, and for the emotional stability it brings to it.

"Every medical man—every one—should have a hobby, so that he will have within himself some degree of self-sufficiency, some escape from boredom. The home workshop is ideal for the medical person because he or she is always on call and he can easily drop a workshop project he may have in hand and return to it later without losing anything. Just 'leave things as they are.' Not so easy with *some* hobbies."

This paper is published to indicate relaxation for the busy man. If any of our members wish to contribute in like manner, we shall use the material in so far as our space allows.—EDITOR.

The internist who is attracted by working with tools or machinery can today take advantage of vastly improved tools and machinery—developments of wartime. Power-driven light machinery is safer, faster, easier to use and more versatile than ever before. Hand tools are improved. Work can be done either in wood or plastics, and articles of a hundred types can be made for pleasure or profit. It is not necessary for the doctor to completely outfit his home workshop at the beginning. ("How to Plan a Home Work Shop"—Delta Craft Books, Milwaukee, Wisconsin.)

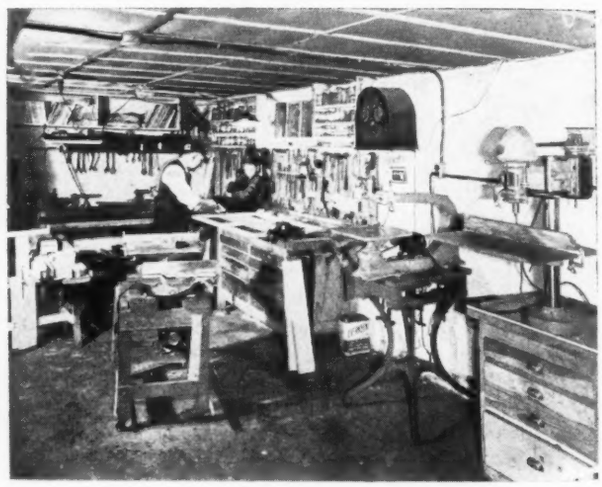

Fig. 2. The shop can be as large as the ambitions of the owner may require.

A brief discussion of the modern home workshop and its installation might be of value to doctors who are anxious to adopt this hobby.

The best location for the shop is in an outbuilding, possibly one end of the garage. Next, the basement of the home will do. The floor should be of concrete or cement covered with rubber matting, wood or linoleum. As a rule two branch circuits wired independenly of each other will provide power, rated at 15 amperes.

Modern light wood- and pastics-working machinery may be introduced to the shop in the following order of importance and usefulness: circular saw, drill press, grinder, lathe, scroll saw, shaper, disk or belt sander, and band saw.

As for initial hand tool requirements: hand drill, hack saw, nail set, oil stone, combination pliers, level, set pocket chisels, combination square, nail hammer, C clamps, cut-off saw, jack plane, screwdrivers, rip saw, folding rule, ratchet brace, and set auger bits.

Of first importance is a good spray booth and spray-

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(Continued from Page 308)

ing gun for paint, varnish or lacquer. Sprayed paint dries faster, comes out smoother with a more professional looking finish.

Daylight for the home workshop is always to be preferred. If not available or limited, step up with proper artificial lighting.

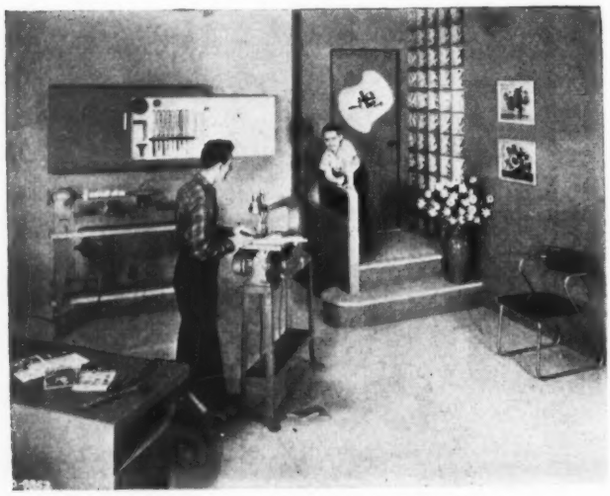

Fig. 3. The shop may be combined with the playroom.

To subdue working noise, the walls and ceilings may be partially treated with acoustical material though most machinery comes on rubber "feet" to deaden sound of operation. Tool cabinets can be hung on the wall to save space and there are plenty of good plans for this which any beginner can follow.

The intern who adopts this hobby will, of course, consider it primarily as a form of relaxation yet one which is productive of many useful articles which may be used, given away, or sold. Also, such a home workshop permits the owner to handle most of the care and repair work around the house and grounds. Here are some of the articles being made by amateurs for use and sale: boats, humidors, boxes, shelving, bird houses, bowls, furniture, dog houses, door knockers, pipe racks, costume jewelry, chests, candy boxes, umbrella racks, ball bats, ash trays, and book ends.

It is often the case that the person introducing this hobby into his home can make the equipment pay for itself. This is done in one of three ways, first, by producing articles to be sold through local stores or direct to neighbors, friends or acquaintances, second, through rentals of tools and equipment along with the shop to neighbors or others, third, by the sale of the products of the hobby to and through bazaars and at other events.

Today, there are thousands of blueprints and plans for making articles of wood, plastics and metals. They are so simple that any one at all handy with tools can follow them with skill and excellent results. The home workshop supplies the owner not only with a physical relaxation but also with a mental and emotional experience. He can, after a hard day or night, "take it out" on a piece of wood and enjoy the thrill of creating something of beauty or usefulness or both.

Yet, a modern wood-working machine is not confined to simple objects for the home. It is possible to do light construction jobs around the home, cutting, shaping and finishing the wood in the shop and assembling and constructing on the spot—a chicken house, for instance.

Where a doctor has a son or daughter in secondary school and taking school shop, the home workshop offers a good opportunity to practice at home those projects that are being studied and worked out in the school.

AMA OFFERS VOLUNTARY MEDICAL CARE PLAN FOR UNITED STATES

(Continued from Page 284)

Klamath Medical Service
Klamath Falls, Oregon

Coos Bay Hospital Association
Marshfield, Oregon

Physicians Association
Oregon City, Oregon

Oregon Physicians' Service
Salem, Oregon

Medical Service Association of Pennsylvania
Harrisburg, Pennsylvania

Group Medical and Surgical Service
Dallas, Texas

Virginia Medical Service Association
Richmond, Virginia

Surgical Care, Inc.
Roanoke, Virginia

Washington Medical Bureau
(17 Plans Included)
Seattle, Washington

Medical Service, Inc.
Charleston, West Virginia

Marion County Medical Service, Inc.
Fairmont, West Virginia

Huntington Hospital Service
Huntington, West Virginia

Central West Virginia Medical Service, Inc.
Weston, West Virginia

Hospital Association of Kentucky and West Virginia, Inc.
Williamson, West Virginia

Wisconsin State Association Plan
Madison, Wisconsin

Surgical Care
Milwaukee, Wisconsin

A wit calls it the WORRY-MAGGY-DINGLE Bill.

Editorial Comment

COMPULSORY HEALTH INSURANCE

According to Arthur Sears Henning, "The compulsory health insurance plan is chiefly the brain child of Isadore S. Falk, research director of the Social Security Board, and Michael M. Davis, a member of the CIO Political Action Committee." Neither the President nor Mr. Wagner nor the Social Security Board made any attempt to consult representatives of the American Medical Association in regard to the bill. In spite of protestations by the President and Mr. Wagner that the bill does not constitute socialization of the practice of medicine, it would do just that, and is the effort on the part of a socialistically minded minority to force socialism on our country contrary to our Constitution, which guarantees private industry. The placing of American medicine under bureaucratic control in Washington is just the first step in the regimentation of industry, finance and, eventually, labor itself.—Editorial, *Minnesota Medicine,* December, 1945.

WHAT ARE YOU DOING ABOUT STATE MEDICINE?

Too many doctors of medicine are becoming indifferent and immune to the Wagner-Murray-Dingell Bill. Too many do not realize that their mode of professional life stops with the enactment of this measure. Too many have themselves been duped by the propaganda of the sponsors of this scheme. Not many realize that this measure will create absolute state medicine for the participants, and that they will become employes of the Government and responsible to the same for their every act. Too many are financially independent and are indifferent accordingly, thus betraying the past and future achievements of the medical science that gave them their knowledge and dignity, and that nurtured them.—Editorial, *Journal of the Maine Medical Association,* January, 1946.

HEALTH INSURANCE INQUIRIES PENDING IN NUMEROUS STATES

"Fourteen compulsory health insurance measures were introduced in the legislatures of six states, and seventeen cash sickness benefit measures were proposed to the legislatures of nine other states," Mr. E. H. O'Conner, Managing Director of Insurance Economics Society of America, told the Industrial Insurers' Conference at its annual meeting in Nashville, Tennessee. "Atlhough none of these measures were adopted in a number of states, legislative study committees have been set up, and the existance of these committees, in addition to known activities in certain other states, gives us every reason to believe that we may expect great activity in the social insurance field as state legislatures come into session during the next two years. Right at this moment, the picture before us is one which seems to call for more attention to the problems of the states than to developments immediately probable in in the federal field.

"Briefly, legislative studies of health insurance or closely related matters have been authorized in the states of California, Washington, Illinois, New York, Virginia, and West Virginia. Strong pressure is believed to be accumulating in the states of Michigan and New Jersey, possibly others."—*Christian Science Monitor,* Dec. 7, 1945.

IMPROVEMENT IN MEDICAL CARE

"Those who are agitating for an elaborate Federally controlled national health program, such as that proposed by President Truman in his message to Congress, lay great stress on the shortcomings of the existing system. They thereby create the impression that individual states and communities have 'failed' to solve the nation's health problem, and that therefore it is time for the Federal Government to take over the job.

"In making that assumption they ignore an impressive movement looking toward improved health care that is now showing intense activity throughout the country. It is a movement not inspired from above but initiated by the communities. It is not revolutionary, but a continuation of a health program that has been going on for years. It is what used to be called typically American, in that it is an effort on the part of the people to help themselves instead of waiting for somebody else to help them."—Editorial, *Baltimore Sun,* January 8, 1946.

(Continued on Page 314)

Is Your Community Awaiting an X-Ray Chest Survey?

Through well-directed educational campaigns sponsored by tuberculosis organizations throughout the nation, men, women, and children have been learning about technological developments which today make it economically feasible to conduct x-ray chest exminations of large groups of people for the purpose of detecting unsuspected tubercular infections in apparently healthy individuals.

Public interest having been so thoroughly aroused, many communities have adopted individually planned x-ray chest survey programs as a most effective measure for tuberculosis control—for screening out and isolating individuals who, "ignorant of the fact that they have the disease, unknowingly jeopardize their own lives and the lives of those with whom they come in contact."

Come the time when such a survey is suggested for your community, and your professional advice probably sought by the local tuberculosis society, we shall be glad to help you prepare a summary which would evaluate the various methods and facilities used for different types of chest surveys. These evaluations, may we assure you, will be unprejudiced, as G-E photo-roentgen apparatus is not limited to but one model, nor restricted to the use of one size of film. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Illinois.

For Your Reception Room—this booklet will prove of absorbing interest to waiting patients. It commemorates the 50th Anniversary of the discovery of x-ray, and recounts the notable contributions of x-ray science, not only to medicine but also to many important phases of industry. Send for your complimentary copy. Ask for Pub. C13.

GENERAL ELECTRIC
X-RAY CORPORATION

The State's Oldest Physician

HOMER PEASE MIX, M.D., Riverside, ninety-four years of age, is Michigan's oldest physician. Born in Orion, Richland County, Wisconsin, October 10, 1851, the physician spent his early years on a Wisconsin farm. After undergraduate study, he taught in rural schools. In 1880, Dr. Mix was graduated from Hahnemann Medical College and Hospital, Chicago. He served an internship at Cook County Hospital and was licensed to practice in Illinois but shortly thereafter took over the practice of a deceased physician in Highland, Iowa County, Wisconsin. Here the occupational accidents that arise in the activities of a lead and zinc mining town introduced him to a type of industrial practice and he was appointed county physician.

In 1883 he was married to Agnes Jenkin of Mineral Point, Wisconsin, daughter of a pioneer hardware and farm implement merchant. In 1908, Dr. Mix moved his family to Benton Harbor and in 1912 to Riverside where the physician remained in active practice until 1945.

The *St. Joseph Herald,* October 12, 1931, stated that forty years of Dr. Mix's career had been spent as a health officer, both in Wisconsin and Michigan.

Throughout his years of practice, Dr. Mix has maintained a direct personal interest in various collections, one in particular being of Indian relics and including hundreds of specimens. One item is a set of candle snuffers once owned by George Washington.

In reviewing his assistance at births, Dr. Mix said his customary fee in the very old days was $10.00. This, he said, he received sometimes in cash, but more often in small potatoes or crooked cord wood.

In 1922 Mrs. Mix died at their home in Riverside, leaving four children, eight grandchildren and two great grandchildren.

The photograph of Michigan's oldest physician was taken on his ninety-third birthday. Our congratulations to Dr. Mix and our felicitations on the good work he has accomplished for his patients, his community and his profession during the sixty-six years of his medical ministrations.

EDITORIAL COMMENT

(Continued from Page 312)

WHO WILL WIN AND WHO WILL LOSE?

Who Will Win?

Who will win if national compulsory sickness insurance is inaugurated in this country?

1. A few physicians who are willing to practice mass medicine, who are willing to abandon the ideals of medicine and render an indifferent, impersonal type of low standard service to the public.

2. A large group of politically minded job hunters who would receive pork barrel appointments as administrators of a vast governmental bureau.

3. Certain politicians, until the time of reaction arrived as a result of the demonstrated defects of compulsory sickness insurance.

Who Will Lose?

1. The taxpayer who will be burdened with a tax for which he receives little in return.

2. The non-taxpayer, the poor, who now receive the best of medical care from our best physicians in accordance with the ideals and traditions of the profession, and who are not provided for under the compulsory program.

3. The public, the gullible public, who accept without question the promises and arguments of politically ambitious persons in favor of national socialism.

4. Industry, which will be taxed a portion of its profits to support a program resulting in more work days lost. This portion of its profits might better be devoted to the salaries of employes to give them more real security.

5. Our community hospitals, which will be forced to abide by governmental regulations and to adjust their standards of service to the lower per diem payment allowed under the Scheme.

6. Our Blue Cross Plans which have demonstrated that the cost of hospitalization can be met for the majority of our people on a voluntary, democratic basis.

7. Our children and our children's children because of lowered health and health standards and through relieving them of the sense that they must be responsible for their own welfare.

8. Our labor unions who disregard the warning of their great leader, Samuel Gompers, when he said in 1916, "For a mess of pottage, under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of libery and freedom, the hope of the Republic of the United States, the leader and teacher to the world of the significance of this great anthem chorus of humanity—liberty!"—Editorial, *Journal, Medical Society of New Jersey,* January, 1946.

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Anal Cryptitis

Its Relation to Focal Infection, Fissure and Fistula

By Wayne W. Flora, M.D.
Chicago, Illinois

Infection of anal crypts and their ducts often produces symptoms and disease processes greatly out of proportion to their apparent importance. Only when we study these structures and perhaps work backward from the pathologic process with which we are dealing as a disease problem to the origin of that disease do we understand their real significance.

Cryptitis is a subject that has been written and talked about for many years either as an entity or in relation to general or local disease. Since the reports of Tucker and Hellwig and Pope before the American Proctologic Society in 1933, emphasizing the importance of anal ducts associated with anal crypts, a number of other authors have studied and written about them. Now we realize how incomplete was our understanding of cryptitis previously. The presence of blind, simple, and branched ducts extending from the crypts into the subepithelial tissues of the anal canal and rectum and some even into their muscular portion furnishes an explanation for the extension of infection into these tissues. The more delicate nature of the secretory type of cells lining these ducts in contrast to the epithelial cell lining of the anal crypts makes the vulnerability of the former to trauma and infection more readily understandable.

Cryptitis may be acute or chronic. Seldom do we see or recognize an acute cryptitis. The acute stage may be recognized as the cause of various types of pain and perhaps spasm of the sphincter. It may be accompanied by tenderness to palpation or instrumental examination, redness of the crypt orifice, edema or bleeding. Chronic cryptitis is most often manifested by increased depth (over 5 or 6 mm.) and hypertrophied anal papilla. There may be a discharge visible in the crypt or granulation tissue within the crypt which may bleed.

Anatomy

The dividing line between the rectum, which is lined by mucous membrane, and the anal canal, which is lined by modified skin, is known by various terms which we use synonymously, namely, pectinate line, dentate line, anorectal line and mucocutaneous line. This line (Fig. 1) is irregular and in some individuals poorly defined. The crypts (Fig. 2) are cone shaped pockets which have their openings at this line pointing upward or internally in the direction of the rectum and their closed portion or apex pointing toward the exterior. The lateral wall of the crypt is the wall of the anal canal and the medial wall is formed by the anal valve (semilunar valve). The anal ducts open into the crypts on the lateral wall. The anal papillae are situated between the anal valves or sometimes on the valve itself. Crypts and papillae vary in number from about three to twelve, usually three to six. In general these structures are more numerous and prominent in infancy and childhood and they tend to disappear in adults.

The external sphincter (Fig. 1) is larger than usually realized. It is divided into three portions,

the subcutaneous, superficial and deep portions, only the first of which is encountered in most anorectal operations. This portion is one of the two important landmarks in anorectal surgery.

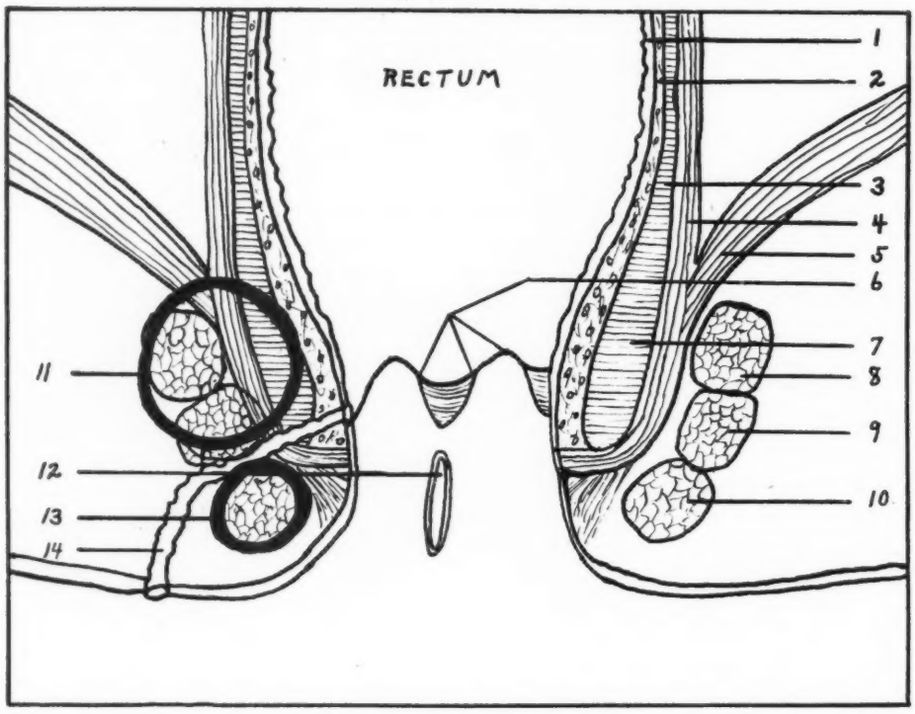

Fig. 1.—Diagram of anal canal (frontal section). (1) Mucosa; (2) submucosa; (3) Circular muscle coat; (4) longitudinal muscle coat; (5) levator ani; (6) anorectal line; (7) internal sphincter; (8) deep external sphincter; (9) superficial external sphincter; (10) subcutaneous external sphincter; (11) anorectal ring; (12) anal fissure; (13) same as 10; (14) anal fistula.

The other is the "anorectal ring" which consists of a group of muscles—the other two portions of the external sphincter, the internal sphincter, the levator ani and the longitudinal muscle layer of the rectal wall. Lateral to these muscular structures are the ischiorectal fossae which are involved in so many cases of fistula.

Focal Infection

The amount of emphasis placed on focal infection varies widely with individuals. Infection in the anorectal region can be a cause of disease elsewhere in the body the same as disease in the teeth, tonsils, sinuses, gall bladder, prostate or any other source. Complaints are registered varying from definite muscle or joint pains to vague complaints such as indigestion, sleeplessness and tiredness. Patients with these kind of symptoms which might be attributed to focal infection should have a thorough examination during which the anorectal region should not be neglected. If diseased crypts are found they should be eradicated. This attitude will not lead to indiscriminate removal of crypts but it will keep attention directed toward them as a possible focus of infection.

Anal Fissure (Ulcer)

Anal fissure or ulcer occurs in the anal canal especially at the posterior midline and less frequently at the anterior midline. The two main predisposing causes are the presence of weak spots in the muscular supports of the anal canal and cryptitis. The posterior midline where a number of sphincter fibers, instead of remaining circular, take a course nearly parallel to each other and insert into the anococcygeal ligament is the weakest portion of the anal canal. Of lesser degree is the defect in the anterior midline where a number of sphincter fibers decussate instead of remaining circular. Infection of a crypt leads to thrombosis of the small vessels in the tissues of the anal canal associated with that crypt making those tissues more susceptible to trauma. Trauma, such as a large or hard stool, foreign bodies in the stool, e. g., small seeds, egg shell, pieces of bone, tooth brush bristles, et cetera, or even frequent thin stools and infection are the active

causes of anal fissure. Sometimes we see a fissure surrounded by or closely associated with varices. These were probably a predisposing factor in causation by reducing tissue resistance and making the tissues more liable to trauma. Likewise they will act as a hindrance to healing. This situation is somewhat related to that of varicose ulcer of the leg. Trauma, infection and poor nutrition of the local tissues on a basis of deficient circulation are common to both conditions.

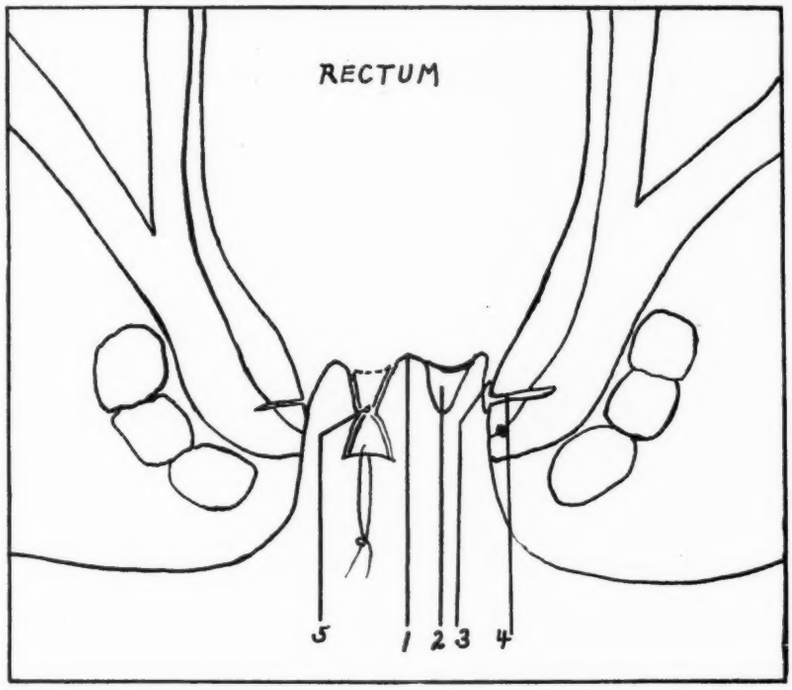

Fig. 2.—Diagram of anal canal (frontal section), showing anal valve cut and turned down to expose lateral crypt wall and duct orifice. (1) Anal papilla; (2) anal (semilunar) valve; (3) anal crypt; (4) anal duct; (5) duct orifice.

For a discussion of treatment, anal fissure is conveniently divided into three groups. The first may not actually be a fissure but it is so closely related that it is well to consider it as such. It is a very superficial linear crack in the skin for which treatment is not commonly sought because of its simplicity. It will heal with no attention or with the simplest treatment. Controlling the consistency of the stools to keep them soft formed by diet, mineral oil or a bulk producing preparation or some combination of these and use of an anesthetic ointment locally is usually sufficient.

The second group is made up of fissures which actually require treatment for relief of pain. The fissure is moderately deep and painful. The borders may be slightly undermined and there will probably be considerable sphincter spasm. Many of this group may be satisfactorily treated by injection. In general, injection treatments follow one of two principles: anesthesia and rest directed to the fissure specifically and anesthesia and rest applied to the anal region generally. The first one, the one which I prefer, is based on the properties of quinine and urea hydrochloride of producing a long lasting anesthesia and a tissue irritation which causes the tissues to become rigid and resistant to motion. This acts as a splint to the fissure. By injecting this solution underneath the fissure and the immediately surrounding tissues and a small amount into the sphincter, pain, spasm and motion will be reduced so the patient will be comfortable and healing will take place. The second injection principle is quite similar but its action depends more on the relaxation of the sphincter by the injection, into and about it, of an anesthetic in oil. Again healing is favored by reducing sphincter spasm and motion in the diseased tissues and pain is reduced due to relaxation of the sphincter. Probably personal experience with a painful lesion of the anal region is necessary for one to really appreciate the amount of activity which takes place in these tissues and the frequent and variable changes which occur in sphincter tone with various body activities. The

therapeutic value of rest in anal fissure is manifested by comfort of the patient and healing of the lesion. The vicious circle (pain and spasm) so uniformly present in cases of fissure is broken by injection treatment.

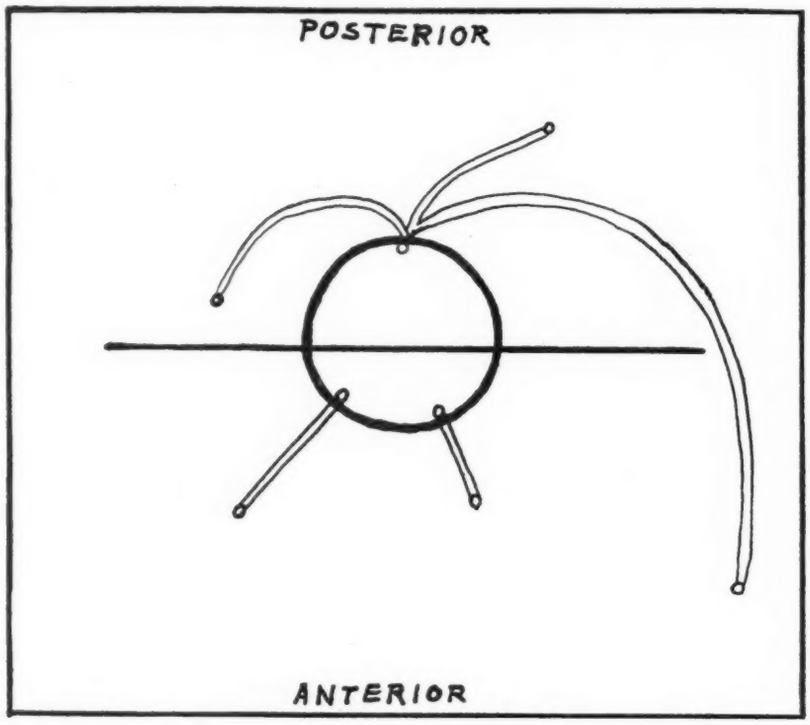

Fig. 3.—Diagram to illustrate Salmon's law.

The third group of anal fissures consists of those which are chronic or recurrent and usually associated with one or more of the following conditions: diseased crypt, hypertrophied anal papilla, sentinel pile, excessive scar tissue or anal contraction. Fissures associated with other surgical diseases of the anorectal region should be treated surgically. Quite often sphincter fibres can be seen in the base of these ulcers. Incision or divulsion for such a lesion is not the best treatment because it does not eradicate the pathological process. Proper treatment consists of excision of the fissure including its fibrous edges and base, its associated crypt, papilla and "sentinel pile," if present, and extension of the external incision onto the skin surface in such a manner that the internal portion will heal first. Careful dilatation of the anal canal should be done to overcome sphincter spasm and when there is a fibrous constriction or a hypertrophied sphincter incision in the posterior midline is advisable.

Anal Fistula

Anal fistula of the common variety only will be dealt with here. This consists of an internal opening at the pectinate line and a channel leading from it to an external opening on the perianal skin. The initial lesion and first stage is infection of a crypt and its duct. The second stage in the process of development is a burrowing of the infection through the wall of the anal canal. The third stage is the spread of the infection into the perianal and ischiorectal tissue with abscess formation. The fourth stage consists of the completion of the fistulous tract by rupture of the abscess onto the skin surface or the incision of the abscess by the surgeon. It is thus seen that fistulae arise internally and result from abscess formation.

As in the case of acute cryptitis previously mentioned, seldom does the patient present himself for examination before the third or even the fourth stage. However, many will seek help early in the third stage and it is in these cases that the doctor can do most to relieve suffering. Contrary to the method of treatment of many other lesions requiring incision and drainage, perianal or ischiorectal abscess should be looked for and treated surgically as soon as the lesion can be located even though

an inch or more of normal tissue may be incised in order to reach a deep abscess. Procrastination or delay only increases the suffering of the patient and leads to further destruction of tissue. Don't wait for this type of abscess to "point." Incise it early and freely, preferably with a crucial incision. Drainage material is best restricted to soft rubber tissue and this for not more than 24 hours. Treatment of the abscess may be considered the first phase of treatment of a fistula and fistulectomy the second phase.

There is some choice about the site of the external opening when it is to be man-made. Salmon's law (Fig. 3) will help determine this choice. This law states that if an imaginary line is drawn between the ischial tuberosities it will divide the anal canal into an anterior and a posterior part, the latter being slightly larger. All external fistulous openings posterior to this line will be connected by a tract with an internal opening at the posterior midline. All external fistulous openings anterior to this line will be connected by a tract extending radially with an internal opening. The exception to the rule is that external openings anterior to the line situated more than about 5 or 6 cm. from the anal margin usually have a tract extending to an internal opening in the posterior midline. By applying this rule at the time of incision and drainage of an abscess the external opening can be made at the most favorable site in view of the fistula operation which will be necessary at some future date.

After the acute inflammatory reaction has subsided fistulectomy should be done. If the fistula is allowed to remain it may act as a focus of infection, abscess formation may recur with possible extension of the fistulous tracts or there may be a dense deposit of scar tissue due to chronic infection. This is especially undesirable about the sphincter. One of the main problems in fistulectomy is to eradicate the source of infection; the diseased crypt and duct. This is done by excising it. The preferred method is to incise the tract and excise infected and scar tissues, being careful not to remove a piece of the sphincter. The incision should be made to extend far enough onto the skin surface to allow the internal portion to heal before the external portion. The wound should be V-shaped and allowed to heal by secondary intention, making sure there is no bridg-

(Continued on Page 360)

Pneumococcic Meningitis Following Head Injuries

By Moses Cooperstock, M.D.
Marquette, Michigan

THE TRUE INCIDENCE of pneumococcic meningitis following cranio-cerebral injuries is not exactly known, but judging from statistics published from hospital services devoted to the care of communicable diseases, the incidence appears to be low. For example, in a series of sixty cases of pneumococcic meningitis treated at the Sydenham Hospital, Baltimore, and the Department of Pediatrics, Johns Hopkins Hospital, from 1938 to 1943, in only one case could a history of head injury be elicited.[4] In another series consisting of fifty-six cases reported by Sweet et al.,[8] three were associated with head injuries. The frequency may be higher on surgical services where such accidents are treated. Munro[7] in a large surgical experience with cranio-cerebral injuries found staphylococci to be the most common organism responsible for meningitis complicating head injuries of all types. Pneumococci were only occasional offenders.

Pneumococcic meningitis is especially prone to occur in compound fractures of the skull involving the paranasal sinuses, cribiform plate of the ethmoid bone or the region of the ear and mastoid through communication established between the subarachnoid and the outside.[1] The escape of cerebrospinal fluid through the nose or ear canal heralds the establishment of such communication and the appearance of cerebrospinal rhinorrhea or otorrhea indicates the imminence of meningitis. Usually, cerebrospinal rhinorrhea occurs early in head-on injuries to the forehead. It may occasionally be delayed in its appearance due to a sealing off of the dural laceration, only to appear later as a result of sneezing or attempts to clear the nose. Cerebrospinal rhinorrhea and otorrhea may be masked by admixture with blood. A comparison of the red cell count of the hemorrhagic discharge in such cases with that of the peripheral blood will help indicate the presence or absence of cerebrospinal fluid.

From the Northern Michigan Children's Clinic.

It is interesting to note that pneumococcic meningitis may occur long after head injury. Etienne-Martin and Pechoux[3] reported a case in which meningitis occurred six months after fracture of the petrous bone. Linell and Robinson[6] in a study of seven autopsied cases, observed three instances in which pneumococcic meningitis developed two and one-half, five and fourteen years after head injury. Pneumococcic meningitis complicating skull fracture may also be of a recurrent nature.[2] The recurrent cases of pneumococcic meningitis of Labby[5] and Tillet[9] developed their initial attacks of meningitis fourteen and two years respectively after their skull fractures.

The instances of recovery from meningitis complicating head injury have been rare. The patient with recurrent meningitis reported by Elvidge and Roseman[2] was successfully treated with sulfapyridine, specific antisera, forced drainage and supportive measures. The patient of Labby[5] and Tillet[9] each responded successfully both with sulfadiazine alone and with sulfadiazine and penicillin in combination. One of the three cases reported by Sweet et al.[8] survived with the employment of penicillin, specific antisera and sulfadiazine.

The following is a report of the occurrence of pneumococcic meningitis complicating head injury with recovery in two children. In one child, the meningitis was associated with cerebrospinal rhinorrhea and in the other, with cerebrospinal otorrhea. Recovery occurred with the employment of sulfadiazine and specific antisera.

Case Reports

Case 1.—R. H., a boy, five years old, was admitted to the hospital August 13, 1942, with a history of a fall from a tractor three days previously resulting in injuries about the face. On admission, the boy was in a stuporous condition. His temperature was 104.6°. A marked depression was present over the bridge of the nose with associated ecchymoses about the eyes. A vertical fracture of the maxillary bone with palpable deformity of the inferior rim bilaterally could be made out on physical examination. Clear cerebrospinal fluid was escaping through the nose. Roentgenograms corroborated the presence of multiple fractures of the bones of the face involving the anterior wall of both maxillary sinuses.

Within twenty-four hours after admission to the hospital, the patient became irrational, developed projectile vomiting and meningeal signs. Spinal fluid obtained by lumbar puncture revealed a cloudy fluid containing 1,560 white blood cells per c. mm. and many gram-positive diplococci on direct smear. Culture of both the spinal fluid and blood revealed pneumococcus, type 21.

During the first twenty-four hours, he received 2 gm. of sodium sulfathiazole intravenously, 2.5 gm. sulfathiazole and 2.0 gm. sulfadiazine by mouth (sulfadiazine would have been the sulfonamide of choice, but this drug as well as sulfathiazole became unavailable). During the second twenty-four hours, the patient received 4.0 gm. sodium sulfapyridine intravenously and on the following day, 3.0 gm. sodium sulfapyridine intravenously. On this day, 30,000 units of type 21 anti-pneumococcus rabbit serum was given intravenously. A larger dose was intended, but intravenous serum was discontinued because of severe serum reaction. Beginning with the fourth day, sulfapyridine was given by mouth, 6.0 gm. daily and this dose was maintained for the next five days, following which the dose of the drug was gradually decreased. In addition, the patient received 200 c.c. of whole blood by intravenous transfusion because of the development of secondary anemia (hemoglobin 60 per cent; red blood count 3,060,000).

By the fifth day of his hospital admission, the patient's temperature had steadily dropped to normal and remained within normal limits thereafter. He was alert and well oriented by the sixth day. His cerebrospinal rhinorrhea had ceased by the eighth day. He was discharged twenty-six days after admission to the hospital. The patient was periodically examined for the following two years. Except for the facial deformity produced by the fracture of the maxillary bones, he presented no residual abnormalities.

Case 2.—R. H., a boy, two years old, was admitted to the hospital June 22, 1943, with a history of a fall down a flight of stairs six hours previously. He did not develop unconsciousness or convulsions, but vomited several times.

The child appeared ill on his admission examination. His pulse was rapid, but was of good quality. His temperature was 100.2°. There was no detectable evidence of skull fracture except for the presence of cerebrospinal otorrhea on the right side. Roentgen studies of the skull showed no definite evidence of fracture, although there was definite clouding of the right mastoid interpreted as indicating the presence of hemorrhage into the mastoid cells.

Up to the third day, the child was treated expectantly. On this day his temperature which had been normal abruptly rose to 103° and he developed symptoms of drowsiness, vomiting and stiff neck. A lumbar puncture performed on the fourth day disclosed the presence of cloudy spinal fluid containing 29,200 white cells per c. mm. The Pandy test was positive and sugar was absent in the spinal fluid. Numerous Gram-positive diplococci were present on direct smear. Culture of the spinal fluid revealed pneumococcus, type 11.

The patient was given 1.5 gm. sulfadiazine by mouth as an intitial dose and 0.5 gm. every four hours thereafter. On this dosage, the patient's temperature gradually reached normal by the seventh day and remained normal until the ninth day of admission when it again became elevated (103°). The spinal fluid white cell count at this time was found to be 80,000 per c. mm. The dose of sulfadiazine was increased from 3.0 gm.

to 4.5 gm. daily and in addition he was given 100,000 units of typespecific, antipneumococcic rabbit serum, 85,000 units intravenously and 15,000 units intrathecally. This was followed by a gradual return of the child's temperature to normal by the seventeenth day and it remained normal thereafter, the patient showing concomitant improvement with the disappearance of fever.

The cerebrospinal otorrhea which was clear and copious on admission became frankly purulent one week after admission and this purulent aural discharge persisted for approximately one month, gradually disappearing. Oral sulfadiazine in gradually reduced dosage was administered for approximately one month after the temperature had dropped to normal. He was discharged seven weeks after admission from the hospital without any apparent residual abnormalities.

Comment

Early operative exposure and repair of the dural tear in the case of skull fractures producing cerebrospinal rhinorrhea is a recommended, emergency, surgical procedure[1] as a measure to prevent meningitis. However, in the case of fractures of the temporal bone involving the middle ear and resulting in cerebrospinal otorrhea, surgical repair of the dural laceration is considered not only a more difficult procedure, but usually one not attended by success. Conservative management appears to be the best form of treatment in such cases. The fact that pneumococcic meningitis complicating craniocerebral injuries of the types illustrated by the two cases reported here can respond successfully to chemotherapy indicates that the sulfonamides offer a powerful weapon not only in the actual development of meningitis, but also strongly suggests its probable value as a prophylactic measure against the development of this dread complication. The therapeutic role of typespecific rabbit serum employed in these two cases was probably a secondary one, since the dosage administered, especially in Case 1 was considerably lower than that successfully used in combination with sulfonamides.[4] Penicillin should constitute an additional prophylactic and therapeutic ally. In fact, recent reports indicate that the combined use of sulfonamides and penicillin yields the best results in the management of pneumococcic meningitis.[8,10]

Summary

Pneumococcic meningitis complicating craniocerebral injuries constitutes an imminent possibility in compound fractures of the skull involving the paranasal sinuses, cribiform plate of the ethmoid bone or the region of the ear and mastoid, especially when accompanied by escape of cerebrospinal fluid. Reported recoveries have been rare.

Two instances in children are described of pneumococcic meningitis, one following a compound fracture involving the paranasal sinuses with resulting cerebrospinal rhinorrhea and the other following an injury to the mastoid producing cerebrospinal otorrhea.

Both children recovered with conservative treatment, employing sulfonamide therapy and typespecific rabbit serum. The outcome in these two cases suggests the importance of the early employment of such potent present-day agents as the sulfonamides, penicillin and specific antisera, not only in the established complication of pneumoccic meningitis, but also from a prophylactic point of view.

Bibliography

1. Brock, S.: Injuries of the Skull, Brain and Spinal Cord. Baltimore: Williams and Wilkins Co., 1943.
2. Elvidge, A. R., and Roseman, E.: Recurrent pneumococcic meningitis complicating skull fracture. Canadian M.A.J., 42:460, (May) 1940.
3. Etienne-Martin, P., and Pechoux, R.: Acute pneumococcic meningitis occurring six months after a cranial. traumatism with fracture of the petrous bone. Ann. de méd. legale, 17:355, 1937.
4. Hodes, H. L., Smith, Margaret H. D., and Ickes, H. J.: Sixty cases of pneumococcic meningitis treated with sulfonamides. J.A.M.A., 121:1334, (Apr. 24) 1943.
5. Labby, D. H.: Recurrent pneumococcic meningitis following skull fracture. J.A.M.A., 127:981, (Apr. 14) 1945.
6. Linell, E. A., and Robinson, W. L.: Head Injuries and meningitis. J. Neurol. & Psychiat., 4:23, (Jan) 1941.
7. Munro, D.: Cerebral Injuries. New York: Oxford University Press, 1938.
8. Sweet, L. K., Dumoff-Stanley, Edith, Dowlin, H. F., and Pepper, M. H.: The treatment of pneumococcic meningitis with penicillin. J.A.M.A., 127:263, (Feb. 3) 1945.
9. Tillet, W. S.: Quoted by Labby[5].
10. Waring, A. J., and Smith, Margaret H. D.: Combined penicillin and sulfonamide therapy. J.A.M.A., 126:418, (Oct. 14) 1944.

NOTE: Since this paper was submitted, three additional instances of pneumococcic meningitis following craniocerebral injury have appeared in the literature.

Hartman et al. reported one instance among thirty-four patients with recovery in which sulfapyridine and antipneumococcus serum were employed.

In a series of sixty-seven consecutive cases of pneumococcic meningitis treated with penicillin, Applebaum and Nelson reported two cases with recovery.

Applebaum, E., and Nelson, J.: Penicillin in the treatment of pneumococcic meningitis. J.A.M.A., 128:778, (July 14) 1945.

Hartmann, A. F., Love, F. M., Wolff, D., and Kendall, B. S.: Diagnosis and management of severe infections in infants and children: A review of experiences since the introduction of sulfonamide therapy. IV Pneumococcus meningitis. J. Ped., 27:115, (Aug.) 1945.

MSMS

Wagner-Murray-Dingell Bill

Notice of hearings in the Senate Committee for April 3, 1946. The AMA has been assigned April 17, 1946. The group most interested gets one day, but may submit written testimony.

The Diagnosis and Treatment of Meningitis

By Jacob S. Fine, M.D.*
Dallas, Texas
and
Franklin H. Top, M.D.†
Detroit, Michigan

DURING THE PERIOD from January 1 to December 31, 1943, 519 patients were admitted to Herman Kiefer Hospital with the referred diagnosis of epidemic or meningococcic meningitis. This diagnosis was verified in 316 cases (60 per cent). Of the remainder, 107 cases (20 per cent) represent other types of infection involving the central nervous system. Moreover, ninety-five cases (19 per cent) were conditions that frequently simulate meningitis. The final diagnoses for all of the cases are enumerated in Table I. The purpose of this report is to describe certain observations in connection with the differential diagnosis of meningitis in general and of meningococcic meningitis in particular. Since all cases of meningitis were treated with the sulfonamide drugs, a consideration of the treatment will be undertaken. It is hoped that these observations will be of value to the practitioner of medicine, upon whom largely rests the responsibility for the early diagnosis and treatment of diseases of the central nervous system.

TABLE I. FINAL DIAGNOSIS OF 519 CASES ADMITTED TO HERMAN KIEFER HOSPITAL WITH THE REFERRED DIAGNOSIS OF EPIDEMIC MENINGITIS

Jan. 1, 1943 to Dec. 31, 1943

Diagnosis	Number of Cases	Incidence per 100 Cases
Meningococcic meningitis	316	60.88
Meningococcemia	8	1.54
Pneumococcic meningitis	23	4.43
H. influenzae meningitis	11	2.12
Other types of purulent meningitis	5	0.96
Purulent meningitis, type undetermined	26	5.01
Lymphocytic meningitis, type undetermined	12	2.31
Tuberculous meningitis	7	1.35
Encephalitis	6	1.16
Poliomyelitis	7	1.35
Brain abscess	3	0.58
Spontaneous subarachnoid hemorrhage	8	1.54
Infections of upper respiratory tract	40	7.71
Primary pneumonia	12	2.31
Typhoid and paratyphoid, dysentery	8	1.54
Bacterial endocarditis	3	0.58
Measles	5	0.96
Other conditions occurring once	19	3.66
Total	519	100.00

Meningococcic Infection and Meningococcic Meningitis

Meningococcic infection stems from the nasopharynx. During epidemics the vast majority of persons harbor the organism in the nose and throat without any signs or symptoms; that is, they become carriers of meningococci. When apparent infection results, considerable variations are found in the clinical features of the infection. The organism may remain localized in the nasopharynx, producing a mild nasopharyngitis, indistinguishable from the "common cold." On the other hand, the meningococcus may invade the blood stream producing a fulminating meningococcemia, followed by death within a few hours from the onset of symptoms. More often the organism upon entering the blood stream localizes in one or several tissues of the body, most commonly the skin, mucous membranes, joints or meninges. Meningitis is perhaps the most dramatic manifestation of the septicemia. The signs and symptoms of the meningeal irritation and the increased intracranial pressure frequently overshadow the underlying picture of the general sepsis.

In the typical case of meningococcic meningitis the patient suddenly feels extremely weak and aches all over. A few hours later he feels chilly, then feverish, and has to go to bed. His head begins to ache, at first a dull generalized ache, which gradually increases in intensity. He becomes nauseated and begins to vomit. The next day the headache is intense. It is described as a severe pounding, excruciating pain, worse than anything the patient has ever experienced, and is not relieved by the usual remedies found in the home. The neck is stiff and painful, and the pain is aggravated by motion. Nausea and vomiting may recur several times. Pain develops in the muscles and joints. A petechial skin rash is frequently noted but often may be missed. Prostration and aching are profound, the patient becomes increasingly lethargic and irritable, and by the third day delirium or coma may supervene. In about one-

*Children's Medical Center, Dallas, Texas. Formerly Acting Medical Director, Communicable Disease Service, Herman Kiefer Hospital, Detroit, Michigan.
†Medical Director, Herman Kiefer Hospital, Detroit, Michigan.

TABLE II. DISTRIBUTION OF 316 CASES OF MENINGOCOCCIC MENINGITIS BY AGE GROUPS AND BY NUMBER OF CASES, DEATHS, AND FATALITY RATES, HERMAN KIEFER HOSPITAL

Jan. 1, 1943 to Dec. 31, 1943

Age Group	Number of Cases	Total deaths	Gross Fatality Rate	Deaths Occurring Within 24 Hours	Corrected Fatality Rate
2 mos.–22 mos.	15	1	6.7	1	0.0
2 yrs.– 9 yrs.	61	8	13.1	8	0.0
10 yrs.–19 yrs.	89	7	7.9	2	5.7
20 yrs.–29 yrs.	54	4	7.4	1	5.7
30 yrs.–39 yrs.	39	5	12.8	3	5.6
40 yrs.–49 yrs.	31	8	25.8	1	23.3
50 yrs.–59 yrs.	22	5	22.7	1	19.0
60 yrs.–70 yrs.	5	4	80.0	2	66.7
Total	316	42	13.3	19	7.7
Below 40 years	258	25	9.7		
Above 40 years	58	17	29.3		

third of the cases in this series, prodromal symptoms of a cold or sore throat occurred within a week prior to the onset of the above picture.

Variations in symptomatology are observed during outbreaks of meningococcic meningitis. A fulminating type of infection occurred in 30 per cent of the cases in this study. Within a period of twenty-four hours from the onset of symptoms the patient became comatose or delirious, or presented a picture of prostration and shock closely resembling that seen in surgical shock. Profound coma occurred so abruptly, occasionally without signs of meningeal irritation, that a cerebrovascular accident, uremia, or diabetes was suspected. On the other hand, a small number of patients were observed who gave a history of fever and chills recurring daily for one or two weeks before the onset of meningitis. Occasionally the symptoms were referable to the gastro-intestinal tract, namely, severe abdominal pain with nausea and vomiting and "watery" diarrhea. These symptoms, coupled with fever and prostration, have been responsible for patients being admitted to general hospitals with a diagnosis of intestinal "flu."

Meningococcic infection and meningococcic meningitis may occur at any age. The ages in this series ranged from two months to seventy years. White and colored races were affected equally with respect to their proportion in the population. Table II illustrates the fatality in relation to age. All fatalities under ten years of age occurred within twenty-four hours of admission to the hospital. These cases were of a tragically fulminant nature; the entire disease process, from onset of symptoms to expiration, frequently lasted less than twenty-four hours. As in most types of severe acute infections, the fatality rate among persons over forty years of age is very high. In our series the fatality in this group was three times greater than for the younger patients (Table II).

Sixty per cent of our cases were admitted in an extremely grave condition; that is, they were comatose, delirious, completely disoriented, or in a state of shock. All the deaths occurred among the cases showing the above symptoms. However, it seems impossible to predict the outcome in any individual case, inasmuch as several patients who seemed moribund on admission recovered rapidly. In general, if the patient in coma failed to respond within forty-eight hours after treatment was begun, the prognosis was extremely poor. On the other hand, every patient who was oriented and not in shock on admission to the hospital recovered and the majority were acutely ill.

The diagnosis of meningococcic meningitis is not difficult, particularly during an epidemic. In this series 70 per cent of the cases had a rash involving the skin and often the conjunctivae. The rash was of a petechial or purpuric nature and could be found anywhere in the skin, but most frequently on the chest and extremities. Occasionally, nodular, erythematous, maculopapular lesions were observed, simulating erythema nodo-

sum. Herpes labialis was noted in 15 per cent; these lesions rarely appeared before the third day of the disease. Usually there was some evidence of pharyngitis; the throat was red and often a postnasal mucopurulent exudate was present. In some instances the tonsils were covered with a spotty follicular exudate. The significant findings, however, were neurological and consisted of the positive meningeal signs, namely, stiff neck, Brudzinski and Kernig signs. The Babinski sign was rarely found in this series, and was of little value in diagnosis. Likewise, the tendon reflexes were of no practical diagnostic significance. In some cases they were exaggerated, in others, absent.

Lumbar puncture usually revealed a cloudy or grossly purulent fluid. The average cell count was about 5,000 cells per cmm. The sugar was almost invariably markedly reduced (less than 10 mg. per cent, and the protein was markedly increased (100-200 mg. per cent). Gram-negative intracellular or extracellular diplococci were usually found on stained smear of the sediment, and culture of the fluid revealed the meningococcus in most cases. Early in the course of the disease the organism was frequently isolated from the blood.

Treatment of Meningococcic Meningitis

Sulfanilamide, sulfapyridine, sulfathiazole, sulfadiazine, and sulfamerazine are all effective in the treatment of meningococcic meningitis. Experience to date leads to the belief that sulfadiazine is the drug of choice in that the patient appears to recover from stupor and delirium more rapidly. Moreover, the drug is usually well tolerated, and serious toxic reactions are few. In a few cases in which renal complications occurred and where it was necessary to continue with chemotherapy, we have used sulfanilamide because of its greater solubility. Although our experience with sulfamerazine in this group of cases was not sufficiently great to make any accurate comparison with sulfadiazine, we have gained the clinical impression that the drug is probably as efficient as sulfadiazine and that toxic reactions are remarkably few.

We shall attempt to describe the general principles of treatment which, in our experience, proved very useful. As soon as the diagnosis of meningitis was established by the presence of cloudy spinal fluid, the blood was cultured and the patient received the sodium salt of one of the sulfonamides intravenously. Since we were dealing with large numbers of patients who were admitted in an extremely grave condition, we felt it was important to administer large amounts of the drug parenterally on admission to the hospital to ensure adequate dosage of drug in the early phase of the disease. The dosage of the drug varied with the age and weight of the patient, and the apparent severity of the infection.

As a rule, adults received sodium sulfadiazine in an initial dose of 5 gms. in 100 c.c. of distilled water intravenously, followed by 1,000 c.c. of 5 per cent or 10 per cent dextrose in physiological salt solution. Six hours later 1 to 1.5 gms. of sodium sulfadiazine in 100 to 200 c.c. of physiological salt solution was given subcutaneously. This dosage of sodium sulfadiazine was continued subcutaneously every six hours until the patient had regained consciousness to a degree which permitted subsequent administration by mouth. In general, only four or five clyses of the drug were necessary. Thereafter, sulfadiazine, 1 to 1.5 gms., was given orally every four to six hours. Generally, there was marked clinical improvement on the fifth or sixth day of treatment, and the dose of the drug was decreased to about one-half. Sulfadiazine was discontinued completely if the patient displayed clinical well-being with the temperature normal for forty-eight hours, and with meningeal signs completely absent. The average duration of sulfonamide therapy was nine days, and the patient was discharged on the eleventh hospital day for further convalescence at home.

The dosage mentioned above is based upon body weights of approximately 150 pounds. Proportionately smaller doses were given to children and patients weighing less than 150 pounds. For example, a patient weighing 75 pounds would receive one-half the average adult dose. A relatively greater amount of the drug should be given to critically ill infants. An initial intravenous dose of 5 per cent sodium sulfadiazine or an initial subcutaneous dose of 1 per cent sodium sulfadiazine containing the equivalent of 1 gr. per pound of body weight is indicated. This should be followed every six hours by a subcutaneous administration of 1 per cent sodium sulfadiazine containing the equivalent of ¼ gr. per pound of body weight. The oral dosage of sulfadiazine consists of a total of 1 gr. per pound of body weight per twenty-four hours divided into four or six equal parts.

The optimum blood sulfadiazine level is not known. The average of the blood sulfadiazine levels taken forty-eight hours after the beginning of treatment was 14 mgms. per cent. However, there was a wide variation in individual cases.

It is imperative to give adequate amounts of fluid, particularly during the first few days of treatment, and most of the fluids have to be given parenterally. Adults must receive at least 3,000 c.c. per day.

The barbiturate and paraldehyde have proven extremely useful for the control of exictement and delirium. Morphine should not be used during the first few days of illness because of its depressant effect upon a patient with increased intracranial pressure. Codiene is useful for the control of headache.

Frequent lumbar punctures are not necessary. In general, the only specimen of spinal fluid obtained was the one on admission. The indication for subsequent lumbar puncture is the determination of progress in a doubtful case or on very rare occasions to reduce dangerously increased intracranial pressure. An evaluation of the clinical picture is sufficient to determine recovery from meningitis.

Complications in this group of cases were relatively few. The most distressing complication was a persistent bilateral eighth nerve deafness which was noted in seven patients. Arthritis involving one or more joints occurred in 19 patients, all of whom recovered completely; and aspiration was necessary in only two cases. Only one infant developed hydrocephalus.

Other Types of Purulent Meningitis

Pneumococcic Meningitis.—Pneumococcic meningitis is probably the most common form of acute purlulent meningitis except during those periods when meningococcic infection is epidemic. Most cases of pneumococcic meningitis are complications of otitis media, mastoiditis, and sinusitis. Pneumonia, acute bacterial endocarditis and skull fracture are other less common sources for this type of infection. In seventeen of our twenty-three cases in this series the primary sources were discovered. They were as follows: otitis media and mastoiditis, eleven cases; sinusitis, three; pneumonia, two; and endocarditis, one. Frequently, the source was not discovered until postmortem examination. Often a pneumococcic infection of the middle ear develops in an insidious manner, producing a few symptoms or signs until the sudden onset of meningitis. In these cases the tympanic membrane may appear normal or only slightly thickened, despite extensive destruction of the mastoid cells. A history of impairment of the hearing for three or four days before the onset of the acute symptoms of meningitis should always arouse suspicion of pneumococcic meningitis secondary to otitis media even when the otological findings are negative.

TABLE III. DISTRIBUTION BY AGE GROUPS OF TWENTY-THREE CASES OF PNEUMOCOCCIC MENINGITIS, WITH NUMBER OF CASES, DEATHS, AND FATALITY RATES, HERMAN KIEFER HOSPITAL

Jan. 1, 1943 to Dec. 31, 1943

Age Group	Number of Cases	Total Deaths	Gross Fatality Rate
Below 40 years	12	4	33.3
Above 40 years	11	9	81.8
Total	23	13	56.5

Any type of pneumococcus may invade the meninges, and there is no apparent relationship between the type of the organism and the gravity of the disease. Type 3 pneumococcus was found most frequently in our series and in every case was associated with otitis media.

Without treatment pneumococcic meningitis is highly fatal. Our group of patients was treated for the most part with sulfadiazine alone and had a fatality rate of over 50 per cent. The disease may occur at any age, and as in meningococcic meningitis the fatality among patients over forty years of age is disproportionately high (Table III).

At one time immediate surgical treatment of infected sinuses or mastoids was thought to be imperative. Our experience indicates that the patient should be treated conservatively and that any surgical procedure should be deferred until the patient's condition has greatly improved. Foci of infection may clear with sulfonamide therapy. However, in such instances, observation should be continued for several months after recovery, because of the possibility that the recovery may be more apparent than real.

Hemophilus Influenzae, Type B Meningitis (Influenza Bacillus, Pfeiffer Bacillus).—Hemophilus influenzae, Type B, meningitis is predominantly a disease of infancy and early childhood. Of the eleven cases in this series, nine occurred in infants

in the first two years of life. The other two were in children three and four years old, respectively. This form of meningitis has no particular relation to epidemic influenza, which is a virus disease of the respiratory tract. H. influenzae meningitis is apparently an invasion of the meninges from the nasopharynx via the blood stream. Meningitis in infancy without the presence of petechial lesions in the skin should provoke a suspicion of H. influenzae infection even during outbreaks of meningococcic infection. Consequently it is imperative to identify the etiologic agent to provide the diagnosis. In infants under one year of age the recognition of meningeal involvement is exceedingly difficult, and clear-cut meningeal signs appear relatively late in the course of the disease. The presence of unexplained fever associated with lethargy, irritability, a high-pitched cry, and a glassy, vacant expression are indications for lumbar puncture. Without treatment practically every infant or young child succumbs to the disease. At the present time, when the use of sulfonamide drugs is combined with type specific anti-influenzal rabbit serum, the prognosis is excellent. Of nine patients treated in this manner only one expired.

Streptococcic Meningitis.—Streptococcic meningitis, like pneumococcic meningitis, is usually secondary to otorhinogenic infections. It is indeed amazing to note that only one case of hemolytic streptococcic meningitis was seen in Herman Kiefer Hospital during the year 1943. This may be explained partly by the unusually low incidence of hemolytic streptococcic infections in the city for that period. Possibly the widespread use of sulfonamides may have been a factor.

One case of Streptococcus veridans meningitis was seen during the same period and this was associated with fracture of the skull.

Staphylococcus Aureus Meningitis.—Staphylococcus aureus meningitis is comparatively rare. Two cases were seen during this period. A history of a furuncle of the face or the presence of staphylococcic infection elsewhere in the body was noted. (The original furuncle was completely healed and not observed on physical examination.)

Diagnosis and Treatment of Other Types of Purulent Meningitis.—Apart from the petechial lesions so commonly associated with meningococcic infections, there are no clinical diagnostic criteria which permit an accurate differential diagnosis of the various types of purulent meningitis. The clinical picture, the symptoms and signs are essentially similar. In general, the presence of a concomitant focal infection such as otitis media or sinusitis make pneumococcic or streptococcic meningitis more likely. The appearance of the spinal fluid and the chemical findings may be similar. The only valid differential factor is the isolation of the etiologic organism from the spinal fluid or blood.

Sulfadiazine is probably the drug of choice in the treatment of all types of purulent meningitis. The general principles of treatment are similar to those outlined in the discussion on meningococcic meningitis with this important exception, that the drug be continued in full dosage for longer periods of time. Moreover, periodic lumbar punctures should be made in these cases to evaluate progress of the disease, since exacerbations and remissions are common, and clinical evaluation alone is often treacherous.

Serotherapy in the Treatment of Purulent Meningitis.—Our experience with serotherapy as an adjunct to the sulfonamides has been limited. In the present series only six patients with meningococcic meningitis and four patients with pneumococcic meningitis received serum in addition to sulfadiazine; only one patient with meningococcic meningitis recovered. It should be added that the above experience does not constitute a fair trial, since all of these patients were moribund on admission.

Penicillin in the Treatment of Purulent Meningitis.—Reports in recent literature indicate that penicillin is an effective agent in the treatment of meningococcic, pneumococcic, streptococcic, and staphylococcic meningitis. Our experience with penicillin in this group of cases has been limited to three cases of pneumococcic meningitis which were refractory to apparently adequate sulfadiazine therapy. The result was unsatisfactory in one case in which the penicillin was administered parenterally alone. In the other two cases rapid recovery followed the combined intrathecal and parenteral administration of the drug. The dosage employed intraspinally was 10,000 units every twelve hours for five days, followed by 10,000 units daily for another five days.

Other Central Nervous System Conditions Simulating Purulent Meningitis

Tuberculous Meningitis.—Tuberculous meningitis is a complication which follows the dissemination of tubercle bacilli from a focus elsewhere in the body, as in the lung or bronchial lymph nodes. The disease occurs most frequently in infants and young children. In most cases there is a gradual onset with few symptoms and little or no fever. The disease is usually not recognized until a later stage, when pronounced evidence of brain disease occurs. Somnolence, bizarre neurological findings, and occulomotor palsies characterize this stage. In one-fourth of the cases a history of contact with tuberculosis is obtained and in three-fourths there is Roentgen evidence of a pulmonary process. The spinal fluid findings are characteristic. The average cell count is 250 cells, mononuclear cells predominating. The sugar is almost always reduced (about 30 mgm. per cent or below), and the protein is moderately increased. The tubercle bacilli are difficult to isolate on stained smear.

From the clinical standpoint alone it is impossible to differentiate tuberculous meningitis from encephalitis. The presence of the reduced value for sugar in the spinal fluid in tuberculous meningitis is an important diagnostic feature. In adults an acute fulminating onset, simulating acute purulent meningitis, occurs more frequently than is commonly realized.

Poliomyelitis.—The symptoms of poliomyelitis often simulate those found in meningitis, namely, headache, fever, stiff neck, pain along the spine, nausea, vomiting and diarrhea. Clinically, there are important differences that make the physician suspect poliomyelitis rather than purulent meningitis. The stiffness of the neck is more voluntary and can be overcome by a steady pressure. Head drop, which occurs frequently in poliomyelitis, has not been observed in our cases of meningitis. The patient with poliomyelitis appears apprehensive and alert in contrast to the lethargy or excitement found with meningitis. Coma and delirium are not seen except in the rare case of polioencephalitis. Weakness and loss of muscle function of the extremities have not been observed in the early cases of purulent meningitis.

The most important evidence in differential diagnosis is obtained from an examination of the spinal fluid. In poliomyelitis the spinal fluid is usually clear or slightly hazy and contains an average of 100 cells per c.mm. Lymphocytes are usually the predominant cell. Very early in the course of the disease polymorphonuclear cells may predominate but patients are usually not seen in this stage by the physician unless an epidemic is present. The sugar content is normal and the protein concentration is moderately increased (50 to 80 mg. per cent).

Lymphocytic Choriomeningitis.—The onset of lymphocytic choriomeningitis is frequently preceded by a minor respiratory infection which subsides before the signs of meningeal irritation appear. The physical signs and the symptoms of meningitis in this disease are essentially similar to those found in any acute purulent meningitis, except that coma and convulsions are unusual. The course of the illness is benign and there are no complications. The spinal fluid shows the following: a cell count ranging from 100 to 1,000 cells per cmm., 90 per cent of which are lymphocytes; the sugar is normal and the protein is normal or slightly elevated.

Isolation of the virus from the spinal fluid or the demonstration of neutralizing antibodies in the blood serums of convalescent patients is the only certain method of making a diagnosis in lymphocytic choriomeningitis. It is impossible both clinically and from the spinal fluid examination to differentiate this entity from preparalytic poliomyelitis, mild forms of epidemic encephalitis and mumps meningitis without parotid swelling.

Encephalitis.—Apart from polioencephalitis, St. Louis encephalitis and equine encephalomyelitis are the only two types of virus encephalitides which have thus far occurred in epidemic form in this country. Like poliomyelitis they occur in the summer. Usually there is an abrupt onset of headache, fever, mental confusion, and signs of meningeal irritation. In severe cases coma and convulsions appear early in the disease. The acute phase of the illness usually subsides in about ten days, and most of the deaths occur within the first three days of the illness. The cerebrospinal fluid reveals slightly elevated protein (60 mgm. per cent), a normal or slightly increased sugar (60-100 mgm. per cent), and a cell count from 50 to 200 cells per cubic millimeter, mononuclear cells pre-

dominating in St. Louis encephalitis whereas polymorphonuclear cells predominate in the early stages of equine encephalomyelitis. The clinical diagnosis of sporadic cases is extremely difficult. The final etiologic diagnosis can be made only with laboratory aid.

Encephalitis lethargica, or von Economo's disease, has been extremely rare in this country during the past ten years. It appeared in 1916, increasing to a peak in 1925, and declined during the next decade. The etiology has never been established. Most of the cases referred to this hospital as "sleeping sickness" have turned out to be tuberculous meningitis.

Our experience with the encephalitides has been limited almost exclusively to the type associated with measles and German measles. The diagnosis is easy because of the concomitant or preceding exanthem. About four to six days after the onset of the rash and the patient has already begun to improve, there is an acute onset of fever and convlusions followed by coma and delirium. In milder forms the patient becomes lethargic and drowsy. Most of these cases show signs of meningeal irritation as well as disturbance in the deep reflexes and positive Babinski signs. Tremors and muscular twitchings are frequently present. The spinal fluid usually reveals 30 to 100 mononuclear cells per cubic millimeter; the sugar is normal; and the protein is mildly increased. In one-fifth of the cases the spinal fluid findings are normal. Sequelae in the form of mental retardation or emotional instability are common.

Brain Abscesses.—In our experience, intracranial abscesses are nearly always secondary to suppurative disease located in the lung, middle ear, mastoid cells and paranasal sinuses. The diagnosis of brain abscess is made more often by the history and course of the disease than by the general symptoms, which are similar to those found in meningitis. Indeed, it is frequently difficult to distinguish between meningitis and abscess, since an area of localized meningitis is often found adjacent to an abscess. Localizing neurological signs, usually a hemiplegia, occur when an abscess invades the motor area of the cerebral cortex. However, a large proportion of these lesions, often of considerable size, may exist in "silent" areas of the brain without any definite signs of symptoms. In general, the cerebrospinal fluid is slightly turbid, containing 200 to 500 cells per cubic millimeter, predominantly polymorphonuclears. The total protein is slightly increased (50 to 80 mgm. per cent); the sugar is normal; no bacteria are present.

Spontaneous Subarachnoid Hemorrhage.—Spontaneous subarachnoid hemorrhage is usually the result of rupture of a pathological artery of the brain. In younger individuals rupture of an artery immediately adjacent to the subarachnoid space, usually an aneurysm in or near the Circle of Willis, occurs most frequently. In patients over fifty years of age, particularly in those associated with hypertension, intracerebral hemorrhage occurs with ultimate extension of the bleeding to the ventricles or subarachnoid space. Occasionally a rapidly growing brain tumor may give rise to subarachnoid hemorrhage.

In spontaneous subarachnoid hemorrhage there is a sudden onset of headache and a change in the mental state which may vary from mild mental retardation to profound coma. Stiff neck is present. Usually there is a slight fever and a mild leukocytosis. This condition is easily differentiated from meningitis by the presence of a bloody spinal fluid, on lumbar puncture.

Other Conditions Simulating Meningitis

Grippe, influenza, or streptococcic sore throat present a picture similar to acute meningococcic septicemia, with headache, chilliness, chills, backache, muscle ache, vomiting, and prostration. In infants and children more alarming manifestations may occur, such as convulsions, extreme irritability, drowsiness, or stupor. Frequently resistance of the neck to flexion is present. This is due more often to pain or enlarged, tender, deep cervical nodes than to the true rigidity of muscle spasm found in purulent meningitis. Eight per cent of cases referred here as meningitis fall into this category. Likewise, a number of cases of meningococcic infection were first diagnosed as influenza or streptococcic throat by the physician before the true nature of the disease became evident. From a practical point of view patients presenting such symptoms, particularly during outbreaks of meningitis, should receive sulfonamides. The temperature is not a safe guide as to the probable severity of the infection. Of greater importance is the general appearance of the patient, particularly the degree of prostration present.

Especially in infants and young children cerebral symptoms may dominate the picture in certain cases of primary pneumonia, typhoid, Salmonella infections, and dysentery. There may be an abrupt onset marked by a sudden rise of temperature and vomiting, followed by chills and headache. Convulsions, delirium or stupor may occur. Stiff neck as well as other signs of meningeal irritation may be present. Without a lumbar puncture it may be impossible to exclude meningitis. Occasionally otitis media in infancy presents an alarming picture, characterized by severe nervous manifestations and convulsions.

The cerebrospinal fluid in these cases is usually under increased pressure but in all other respects is normal except that the sugar content may be mildly increased. This is probably due to the concomitant increase in the blood sugar, frequently found at the onset of acute infectious disease. On a rare occasion a meningitis with recovery of typhoid or Salmonella organisms from the cerebrospinal fluid may be seen. We have noted one such case in this present series.

Summary

During the period from January 1 to December 31, 1943, 519 patients were admitted to the Herman Kiefer Hospital with the referred diagnosis of meningococcic or epidemic meningitis. A review of the final diagnoses of these cases is presented.

The diagnosis and treatment of meningococcic meningitis as well as certain observations pertaining to the differential diagnosis of the meningitides is considered.

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Grand Rapids Press Comments on Michigan Medical Service

(Continued from Page 296)

making a success of it, has provided a shining example for the rest of the country to follow. What organized medicine has accomplished in this state with the aid of labor unions, large employers and the Blue Cross plan, can become equally effective in other states—and must be, if this nation is not to be forced to swallow the bitter pill of state medicine.—November 9, 1945.

The Epidemiology of Tinea Capitis in Detroit School Children

By Lee Carrick, M.D.
Detroit, Michigan

THE NUMBER OF cases of tinea capitis seems to be increasing in America, especially in the eastern and northeastern-central states, and the number of cases appearing in Michigan is steadily growing.[5,6,13] Most of the cases of ringworm of the scalp being encountered are extremely resistant to local therapy. This can be explained by the fact that the predominant fungus responsible for tinea capitis in the United States and Canada in recent years has been *Microsporon audouini* (Table I), a species which has been notoriously refractory to all treatment short of x-ray epilation of the scalp. As a result, treatment has been unsatisfactory and more and more cases are coming to the attention of the physician. This presents a serious problem to physicians everywhere, especially in urban centers.

In view of the growing epidemiologic importance of tinea capitis, a statistical investigation was carried out between October, 1944 and April, 1945 to determine the incidence of this disease in the school children of Detroit, Michigan and to study certain related problems.

Method

Since the City of Detroit is divided into seven school-health districts (see map of Detroit) it was considered practical to select at random three elementary schools from each district. These schools served as a sample of the city-wide total elementary school enrollment. The principal of each of the twenty-one schools was asked to select

From the Department of Dermatology and Syphilology, service of Dr. Loren W. Shaffer, Professor, Wayne University College of Medicine and City of Detroit Receiving Hospital. Material for this paper is taken from a thesis prepared in partial fulfillment of the requirements leading to the degree of Master of Science in Dermatology and Syphilology.

Dr. Carrick is a Fellow in Dermatology and Syphilology, Wayne University College of Medicine and City of Detroit Receiving Hospital.

TABLE I. INCIDENCE OF FUNGUS SPECIES CAUSING TINEA CAPITIS IN UNITED STATES AND CANADA

Location	Year	Authority	No. Cases	Predominant Fungus	Per Cent
Boston	1899	White[24]	139	M. audouini	94.0
	1923	Greenwood[11]	40	M. lanosum	67.5
Cleveland	1899	Corlett[9]	—	M. audouini	90.0
	1935	Binkley[3]	—	M. audouini	70.0
Buffalo	1899	Wende[23]	90	M. audouini	99.0
Chicago	1915	Beeson[1]	100	Microsporon (species not given)	89.0
	1944	Benedek[2]	140	M. audouini	81.5
Los Angeles	1932	Jacobson[12]	—	M. lanosum	—
St. Louis	1935	Mook[19]	—	"Animal" fungi	—
El Paso	1935	Smith[21]	—	M. audouini rarely found	—
Philadelphia	1935	Weidman[22]	36	M. lanosum and M. felineum	50.0
	1941	Livingood[17]	130	M. audouini	96.2
New York	1935	Lewis[14]	37	M. audouini	54.0
	1939	Lewis[15]	292	M. audouini and M. lanosum	78.9
	1944	Lewis[16]	411	M. audouini	95.4
Lansing	1944	Leeder[13]	620	Causative fungi not determined	—
Flint	1945	Burkett[5]	1145	Causative fungi not determined	—
Detroit	1945	Carrick[6]	56	M. audouini	100.0
Montreal	1924	Burgess[4]	62	M. audouini	29.0
Winnipeg	1933	Davidson[10]	75	M. audouini	57.0
Vancouver	1934	Cleveland[8]	100	M. audouini	100.0

alphabetically every fifth child for examination under the Wood's light*. In this way a sample of 20 per cent among the schools selected was hoped for. Actually, however, the size of the sample was less (16.35 per cent) due to absenteeism on the day selected for examination, failure of some of the children selected to obtain parental consent for the examination plus the fact that some of those chosen were above the age limit (thirteen years) commonly susceptible to tinea capitis and were dropped from the series.

Each student was given a card to be filled out requesting the following information: date of examination, school, child's name, address, age, sex, and color. The teacher was asked to indicate on the card whether, in her opinion, the child's personal hygiene was good, fair, or poor, and her impression of the economic status of the child's family (good, fair, or poor). A space was left for a case number, result of examination under the Wood's light, result of culture for fungi from positive cases, portion of the scalp involved, if positive (occipital, vertex, et cetera), and appearance of lesions.

At the time of the examinations the children filed into a semi-darkened, well-ventilated room and presented their cards to an assistant as they were placed, one by one, under the Wood's light. The examiner's rubber-gloved fingers were run through the hair against the hair currents so as to expose any fluorescent patches of ringworm near the scalp which would have been kept from view by long hair. Upon the discovery of a positive case, the gloved hands were washed in an antiseptic solution and re-checked under the Wood's light for clinging fluorescent hairs before going on to the next child. In this way cross-contamination was avoided. Each child required about thirty seconds for thorough examination of the scalp, and, with this procedure, about 100 children per hour could be examined. In order to keep the line moving rapidly children whose scalps showed fluorescent patches of ringworm under the

*The Wood's light, invented by Robert William Wood, an American physicist, is an ultraviolet light whose rays are passed through a special filter composed mainly of nickel oxide. The best glass, according to Radley and Grant[20], contains 9 per cent of nickel oxide together with silica, barium oxide, potassium oxide, and copper oxide. When a source of ultraviolet light is screened with this glass all the visible rays are absorbed while the ultraviolet rays are transmitted through the filter. Certain substances, such as infected hairs from a case of tinea capitis, fluoresce in a characteristic manner when exposed to the filtered rays in a darkened room.

The first use of the Wood's light in the study of dermatoses, including tineal infections, was by Margarot[18] in July, 1923, and he presented his results before the Congress of Anatomists in Turin in April, 1925.

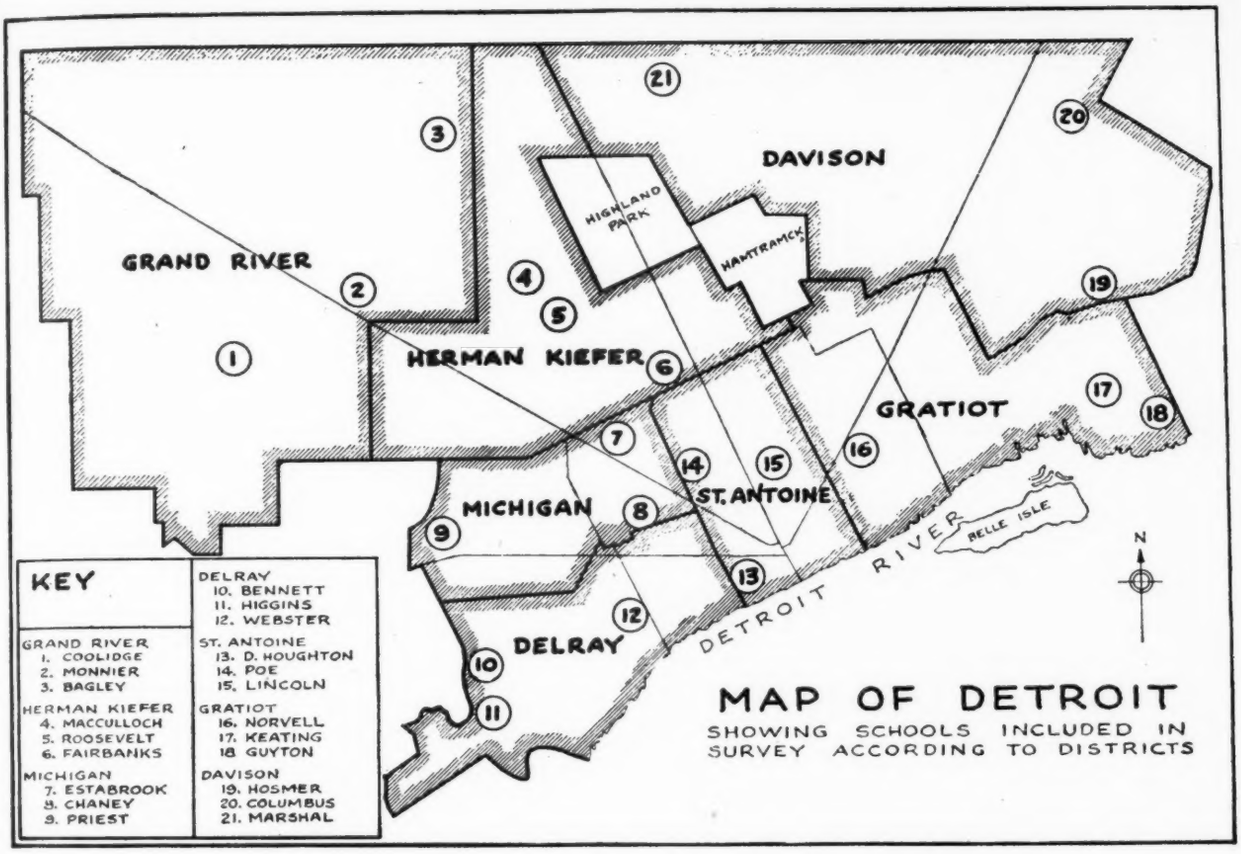

TABLE II. CLASSIFICATION OF DATA COLLECTED IN SURVEY

District	School	School Census	Sample	No. Pos.	Male	Female	White	Col.	Personal Hygiene Good	Fair	Poor	Economic Status Good	Fair	Poor
GRAND RIVER	Coolidge	1320	167	1	85	82	167	0	139	24	4	93	72	2
	Monnier	959	154	1	90	64	154	0	96	47	11	86	64	4
	Bagley	1077	183	1	98	85	183	0	150	30	3	145	38	0
HERMAN KIEFER	MacCulloch	1487	271	1	147	124	271	0	136	110	25	86	170	15
	Roosevelt	1633	205	3	112	93	205	0	118	81	6	83	117	5
	Fairbanks	793	151	6	85	66	151	0	111	34	6	88	59	4
MICHIGAN	Estabrook	758	126	10	62	64	126	0	62	54	10	50	68	8
	Chaney	1110	210	1	114	96	196	14	76	117	17	44	135	31
	Priest	730	117	0	49	68	116	1	66	38	13	45	65	7
DELRAY	Bennett	678	120	0	61	59	119	1	68	47	5	24	93	3
	Higgins	731	94	2	38	56	94	0	51	35	8	22	62	10
	Webster	624	112	2	56	56	96	16	34	61	17	20	65	27
ST. ANTOINE	D. Houghton	669	136	4	70	66	135	1	48	62	26	31	73	32
	Poe	1152	218	6	121	97	204	14	69	109	40	13	141	64
	Lincoln	1401	178	6	94	84	0	178	59	68	51	26	86	66
GRATIOT	Norvell	768	132	9	61	71	5	127	43	65	24	12	68	52
	Keating	1279	223	11	112	111	205	18	138	77	8	100	112	11
	Guyton	814	96	1	48	48	96	0	59	30	7	50	42	4
DAVISON	Hosmer	1042	164	18	88	76	164	0	84	74	6	33	116	15
	Columbus	1149	212	11	114	98	212	0	172	35	5	173	25	14
	Marshall	1631	296	2	152	144	296	0	75	207	14	34	252	10
Total		21805	3565	96	1857	1708	3195	370	1854	1405	306	1258	1923	384

Wood's light were allowed to wait until the entire group had been examined. Then the positive cases were re-examined, one by one, pertinent data recorded on their cards, and fluorescent hairs extracted with sterile forceps and placed between two sterile glass slides. At the laboratory the fluorescent hairs were plated on Sabaroud's maltose agar under a Wood's light and subsequent identification of the fungus was made on gross and micro culture. Duplicate specimens were sent to Duke University for confirmatory culture.

Results and Comments

Of the sample consisting of 3,565 children ex-

TABLE III. DISTRIBUTION OF POSITIVE CASES BY AGE, SEX, AND COLOR

Age	No. Cases	Male	Female	White	Colored
5	5	4	1	3	2
6	12	12	0	10	2
7	14	14	0	10	4
8	19	14	5	16	3
9	14	11	3	12	2
10	19	16	3	16	3
11	6	6	0	5	1
12	5	5	0	5	0
13	2	1	1	1	1
Total	96	83	13	78	18

TABLE IV. INCIDENCE OF POSITIVE CASES BY COLOR

Color	Total No. Examined	No. Positive Cases	Incidence Per 100 Examined
White	3195	78	2.44
Colored	370	18	4.86
Total	3565	96	2.69

TABLE V. INCIDENCE OF POSITIVE CASES BY SEX

Sex	Total No. Examined	No. Positive Cases	Incidence Per 100 Examined
Male	1857	83	4.47
Female	1708	13	0.76
Total	3565	96	2.69

TABLE VI. DISTRIBUTION OF POSITIVE CASES BY SEX AND LOCATION OF LESIONS ON SCALP

Sex	Hairline		Vertex		Generalized	
	No. Cases	Per Cent	No. Cases	Per Cent	No. Cases	Per Cent
Male	65	78	10	12	8	10
Female	2	15	10	77	1	8

TABLE VII. RELATION BETWEEN PERSONAL HYGIENE AND OCCURRENCE OF CASES

Personal Hygiene Classification	Negative Cases		Positive Cases	
	No. Cases	Per Cent	No. Cases	Per Cent
Good	1809	52.1	45	46.9
Fair	1369	39.5	36	37.5
Poor	291	8.4	15	15.6
Total	3469	100.0	96	100.0

TABLE VIII. RELATION BETWEEN ECONOMIC STATUS AND OCCURRENCE OF CASES

Economic Status Classification	Negative Cases		Positive Cases	
	No. Cases	Per Cent	No. Cases	Per Cent
Good	1237	35.7	21	21.9
Fair	1870	53.9	53	55.2
Poor	362	10.4	22	22.9
Total	3469	100.0	96	100.0

amined at twenty-one elementary schools. (Table II), ninety-six (2.7 per cent) were positive for tinea capitis under the Wood's light. On the basis of a total enrollment of 21,805 children thirteen years of age or younger from the twenty-one schools included in the survey, according to this sample the total number of cases of tinea capitis for these schools should approximate 589 cases. Since the approximate city-wide total enrollment of children under fourteen years of age (excluding parochial and private schools) is 220,291, this would mean that there should be about 6000 cases of tinea capitis in the Detroit public elementary schools.

All of the ninety-six cases positive under the Wood's light were due to Microsporon audouini. None of these showed evidence of kerion or secondary infection in the involved areas.

From Table III it will be seen that most of the cases of tinea capitis fell in the age group six to ten years inclusive. These results are similar to those of White[24] (four to nine years), Carrión and Silva[7] (four to eight years), and Benedek and Felsher[2] (four to nine years).

There were eighteen colored and seventy-eight white children with tinea capitis (Table IV). Based on a total sample of 370 colored and 3,195 whites, this means that 4.86 per cent of the colored and 2.44 per cent of the white children had tinea capitis. This agrees with the findings of Livingood and Pillsbury[17] who feel that the Negro race has shown a high susceptibility to ringworm of the scalp.

Of the 1,857 males examined, eighty-three (4.47 per cent) were positive for ringworm of the scalp, while among 1,708 females only thirteen (0.76 per cent) showed evidence of the disease (Table V). Thus the incidence of tinea capitis among the males was nearly six times that among the females.

This ratio of males to females is in agreement with the observations of other investigators, namely, Beeson[1] (5.7:1), Livingood and Pillsbury[17] (6.6:1), and Benedek and Felsher[2] (5.1:1).

TABLE IX. DISTRIBUTION OF POSITIVE CASES ACCORDING TO SCHOOL-HEALTH DISTRICTS

District	Census of Schools Examined	Sample	Number of Positive Cases	Per Cent of Positive Cases
Grand River	3356	504	3	0.59
Herman Kiefer	3913	627	10	1.60
Michigan	2598	453	11	2.42
Delray	2033	326	4	1.22
St. Antoine	3222	532	16	3.00
Gratiot	2861	451	21	4.65
Davison	3822	672	31	4.61
Total	21805	3565	96	2.69

Lewis,[14,15] however, found only three males for each female infected, and Carrión and Silva[7] observed tinea capitis in only slightly greater proportions in males than in females. In general, one is justified in concluding that tinea capitis is much more common in males than in females.

A study was made to ascertain which portion of the scalp was most commonly involved in each sex. As shown in Table VI, 78 per cent of the infected males had ringworm around the hairline (occipital and/or temporal areas), while only 15 per cent of the infected females had involvement in this region. Only 12 per cent of the infected males had vertex involvement, while 77 per cent of the infected females had ringworm in this area. Multiple patches of tinea capitis over the entire scalp (generalized) were found in 10 per cent of the infected males and in 8 per cent of the infected females. In this connection, Livingood and Pillsbury[17] observed that more girls than boys had tinea capitis in the vertex area where the hair is parted and that girls are rarely infected along the hairline and nape of the neck, the length of their hair preventing infected, broken-off hairs from reaching the scalp.

Finally, a word should be said regarding the common assumption that ringworm of the scalp is predominantly a disease of children of low economic status and poor personal hygiene. Carrión and Silva[7], in their study of thirty-five cases in Puerto Rico, found twenty-six (74.3 per cent) in children belonging to poor families living under poor hygienic conditions. The remaining nine cases (25.7 per cent) came from well-to-do families. Likewise, Livingood and Pillsbury[17], of Philadelphia, felt tinea capitis to be related to poverty and poor hygiene. It should be noted, however, that the large majority of the Puerto Rican cases were from a dispensary and the Philadelphia survey was made among families of the lower economic stratum of central south Philadelphia.

Because of this supposed relationship between tinea capitis and poverty and poor personal hygiene, a special endeavor was made in the present study to evaluate these factors statistically. Since the random selection of schools for the survey did not include private schools, the effect of well-to-do families on the result could not be determined. As the map of Detroit shows, however, the schools included in the survey are fairly well distributed throughout metropolitan Detroit, and, in selecting them, no attempt was made to favor one social-economic portion of the city over another. Poor districts as well as upper middle-class areas were given equal representation. The classification of each child as to personal hygiene and economic status was made on the basis of the teacher's personal impression.

A study of Table VII reveals that when the negative cases are compared with the positive cases the latter group includes a smaller percentage of children classified as having good personal hygiene and a larger percentage as having poor personal hygiene. It would seem, therefore, that personal hygiene may have some influence in the occurence of tinea capitis.

Likewise, a study of Table VIII reveals essentially the same findings for economic status, that is, negative cases tend to be associated with good economic conditions and positive cases tend to be associated with poor economic conditions.

As indicated in Tables II and IX, and in the map of Detroit, the highest incidence of tinea capitis occurred in the Gratiot and Davison districts which, in general, are populated by families of middle class, rather than those of poor, economic

status. Although this study shows a high incidence of tinea capitis in colored children and a moderately high incidence in those children classified as of poor economic status and personal hygiene, a markedly higher incidence in these districts (Gratiot and Davison) and a variable incidence in other districts would suggest that economic status and personal hygiene play a rather minor rôle in the distribution of tinea capitis. There is a variation in the incidence in districts suggesting other epidemiologic factors which have not as yet been determined. Incrimination of schools, theater seats, et cetera is hardly warranted on present epidemiologic evidence. Although no significant data was collected in this survey to determine the rôle of the barbershop in the epidemiology of tinea capitis, it would seem justified to suspect hair clippers, especially, and combs and brushes as an important means of spread of this disease. The greater incidence of scalp ringworm in boys plus the more frequent involvement of the hairline area in boys would point toward the unsterilized barber instrument as a source of spread regardless of whether they are used by a barber or by the child's parents at home. This tends to confirm the growing impression that such instruments are probably the most important single means of spread of tinea capitis.

The question of the management of tinea capitis and results of an investigation of some of the newer fungicidal agents effective against Microsporon audouini will be the subject of a future report.

Summary and Conclusions

1. Tinea capitis exists among the Detroit elementary public school children, and all positive cases found in this survey were due to Microsporon audouini.

2. Of 3,565 children selected at random in a city-wide survey, 96 (2.7 per cent) showed evidence of tinea capitis under the Wood's light.

3. On the basis of total enrollment of children susceptible to tinea capitis there are about 6,000 cases of ringworm of the scalp in the Detroit public schools.

4. In this series of ninety-six cases of tinea capitis the greatest number of cases occurred between the ages of six and ten.

5. Six boys for each girl were infected.

6. The percentage of tinea capitis in this survey was greater in the colored than in the white children.

7. In the males the hairline area was most commonly involved, while most of the females had vertex involvement.

8. The results presented would seem to indicate that personal hygiene and economic status may have an influence on the occurrence of tinea capitis but they are not the major factors.

9. Barber instruments, especially hair clippers, should be suspected as an important source of spread of tinea capitis.

Acknowledgments

The author wishes to express his appreciation for the assistance rendered in this study to the following:

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Bibliography

1. Beeson, B. B.: Ringworm of the scalp in Chicago: A bacteriological study of one hundred cases. J. Cut. Dis., 33:731, 1915.
2. Benedek, T., and Felsher, I. M.: Epidemiology of tinea capitis. Arch. Dermat. & Syph., 49:120, 1944.
3. Binkley: Cited by Lewis, G. M.[14]
4. Burgess, J. F.: Fungus infections of the skin. Arch. Dermat. & Syph., 12:853, 1925.
5. Burkett, L. V.: Present status of ringworm epidemic. Bull. Genesee County M. S. (Mich.), 17:6, (Jan. 23) 1945.
6. Carrick, L.: Unpublished data.
7. Carrión, A. L., and Silva, M.: Ringworm of the scalp in Puerto Rico. Puerto Rico J. Pub. H. & Trop. Med., 19:329, 1944.
8. Cleveland, D. E. H.: Cited by Lewis, G. M., and Hopper, M. E.[15]
9. Corlett, W. T.: Recent researches in ringworm. J.A.M.A., 32:589, 1899.
10. Davidson, A. M., and Gregory, P. H.: Kitten carriers of microsporon felineum and their detection by the fluorescence test, Canadian M. A. J., 29:242, 1933.
11. Greenwood, A. M.: Report on cultures of parasitic fungi. Arch. Dermat. & Syph., 8:81, 1923.
12. Jacobson, H. P.: Fungus Diseases, p. 17. Springfield, Illinois: Charles G. Thomas, 1932.
13. Leeder, F. S.: Personal communication.
14. Lewis, G. M.: Ringworm of the scalp. Am. J. M. Sc., 189:364, 1935.
15. Lewis, G. M., and Hopper, M. E.: Introduction to Medical Mycology. Chicago: Year Book Publishers, 1943.

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The Effects of Small Doses of Penicillin Administered to Patients with Undiagnosed Early Syphilis

Report of Three Cases

By Comdr. Thomas H. Miller, MC, USNR*

PENICILLIN is the first therapeutic agent to prove of value in the treatment of both syphilis and gonorrhea. Its introduction has been fraught with the usual difficulties attendant upon every attempt to evaluate a new drug or biologic. A problem which has already been cited in the literature is the danger inherent in the use of penicillin in cases where concomitant infection with syphilis and gonorrhea has occurred. Because the curative dose for the latter is but a fraction of that which is considered adequate for the treatment of syphilis, its use may mask the clinical development of an unrecognized syphilitic infection and delay the diagnosis indefinitely. This is likewise true in all instances where small doses of penicillin are administered to persons having undiagnosed syphilis.

Van Slyke[5] called attention to this. He recommended that microscopic examination of lesions be made before penicillin is administered and that a blood test for syphilis be taken sometime after treatment for gonorrhea has been completed. Shafer and Zakon[4] briefly described a case in which 100,000 units of penicillin given for gonorrheal urethritis was followed by a papulopustular eruption and a positive blood serologic reaction several weeks later. The cutaneous lesions healed rapidly under combined arsenical and heavy metal therapy. Canizares[1] reported a case of concomitant infection with gonorrhea and syphilis which was treated with 50,000 units of penicillin thirty-one days following the last sexual contact. A penile ulcer containing spirocheta pallida appeared at the site where a papule had been noted for nineteen days previously. The author advocated that patients who are treated for gonorrhea with penicillin be kept under observation for syphilis for a period of one year or longer. Hailey[3] in reporting a similar case, stressed the desirability of thorough and repeated laboratory studies to rule out syphilis before penicillin is used.

Three cases of gonorrheal urethritis treated with intramuscular injections of 100,000 Oxford units of penicillin are reported. In each instance, an unrecognized early syphilitic infection was present at the time that the penicillin was given. It is hoped that further reports of cases receiving syphilitically inadequate doses of penicillin for gonorrhea or other infections which subsequently present signs and symptoms of early syphilis will be forthcoming. It is desirable that a standard method of diagnostic and therapeutic procedure for the management of such cases be established.

Report of Cases

Case 1.—An adult, colored man, nineteen years of age, was admitted to the hospital on November 26, 1944, complaining of bleeding from the rectum. One month previously, the patient had occasionally noticed a small amount of bright red blood following defecation. Subsequently, he was able to feel a slight depression near the anus and a small blood clot was removed on one occasion. The lesion was not painful. Three days prior to admission, a tender swelling had appeared in the right groin.

According to the record, a urethral discharge had appeared on June 26, 1944, seven days after unprotected sexual contact. The patient did not seek medical advice and the discharge disappeared after he had taken sulfathiazole for four days. There was no further sexual exposure but on July 15, 1944, the discharge recurred. He then reported to sick call and the exudate was found to contain Gram-negative intracellular diplococci. A total dose of 100,000 units of penicillin was administered, the urethritis subsided and the patient was discharged on July 24, 1944. The Kahn blood test was negative on July 20, 1944. The patient denied any sexual contact during the period between his discharge to duty and his re-admission for the present complaint.

Upon physical examination a crateriform ulcer 1 cm. by 2.5 cm. was seen at the border of the anal orifice posteriorly. The borders were slightly raised and indurated and the base consisted of relatively clean granulations. A small, eroded papule was present at the mucocutaneous junction of the prepuce dorsally. A

*The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

Comdr. Miller is assistant professor in Dermatology and Syphilology, Wayne University, College of Medicine, on leave of absence. He has been medical officer in the U. S. Naval Reserve since August 21, 1942, and is now on inactive duty, 1305 David Whitney Bldg., Detroit 26, Michigan.

slightly tender, palpable lymph node was present in the right groin. The general physical examination was otherwise essentially negative.

Urinalysis and a complete blood count were within normal limits. The blood Kahn and Kolmer Wassermann reactions were positive. The Frei test was considered negative (4 mm. papule after seventy-two hours). Darkfield examination of material taken from the right inguinal lymph gland and from the penile lesion revealed no spirocheta pallida present on four separate occasions. Several darkfield examinations of serum from the perianal ulcer showed the presence of spirocheta pallida.

In all, 2,400,000 Oxford units of penicillin were administered intramuscularly in sixty equal doses given at three-hour intervals. Daily darkfield examination of the perianal lesion failed to show the presence of any spirocheta pallida after thirty-six hours of treatment, and the lesion was healed on the sixth treatment day. The right inguinal lymph gland remained palpable but was not tender. The blood Kahn and Kolmer Wassermann reactions were positive after completion of treatment.

Except for headache, nausea, and chilly sensations during the first twenty-four hours of treatment, there was no reaction.

Case 2.—On December 14, 1944, a white man, twenty-one years of age, was admitted to the hospital complaining of painless penile lesions.

On October 1 and November 9, 1944, the patient had unprotected sexual intercourse with two unknown individuals. On November 18, 1944, a purulent urethral discharge was noted and a smear of the exudate showed the presence of gonococci. All signs and symptoms had disappeared on November 20 after the administration of 100,000 units of penicillin.

Two days before the onset of the urethritis a number of filiform, penile warts had been treated by the local application of an acid. Darkfield examination of serum from the largest of the lesions was made on November 19, 1944. No spirocheta pallida were seen. All lesions healed completely and the patient was discharged to duty on November 24, 1944.

There was a recurrence of the urethral discharge on December 5, 1944, although there had been no exposure during the interim. It responded satisfactorily to a course of sulfathiazole but the patient reported at sick call eight days later because of the presence of several penile ulcers. These lesions were located at sites where penile warts had previously been destroyed.

Upon physical examination several filiform verrucae were found in the coronal sulcus of the penis near the frenulun. Three ulcers varying in size from 0.5 cm. to 1.0 cm. in diameter were also present in the sulcus. All had perpendicular borders, clear granulating bases and were indurated. No other cutaneous or mucous membrane lesions were present. The peripheral lymphatic glands were universally enlarged and indurated. No further abnormal physical findings were noted.

A complete blood count was within normal limits. Urinalysis showed a few leukocytes and the blood sedimentation rate (Cutler) was 13 mm. per hour. The blood Kahn and Kolmer Wassermann tests were negative. Darkfield examination showed the presence of spirocheta pallida in serum from the penile ulcers on December 14, 15, and 16.

Treatment was instituted on December 17, 1944; 2,400,000 Oxford units of penicillin were injected intramuscularly in sixty equal doses at three-hour intervals. One hour following the second injection there was considerable edema of the prepuce. Continuous cold compresses of normal saline solution were applied and the treatment was not interrupted. The edema subsided during the succeeding thirty-six hours. No other reaction was noted. The penile lesions were reported darkfield negative on the third, fourth, and fifth treatment days and all lesions were healed completely within forty-eight hours after the completion of treatment. The blood Kahn and Kolmer Wassermann tests remained negative.

Case 3.—A colored man, nineteen years of age, was admitted to the hospital on December 16, 1944, because a routine blood Kahn test had been reported positive. The patient had no complaints.

According to the record, the patient had suffered a rupture of the frenulum of the penis on September 26, 1944, during the course of unprotected sexual intercourse. He received no prophylaxis, did not seek medical advice and states that the laceration healed spontaneously within a week. Six days later a urethral exudate containing Gram-negative, intra-cellular diplococci appeared and cleared up without incident following a course of 100,000 units of penicillin injected intramuscularly. There were no further sexual exposures but the urethral discharge recurred on December 10, 1944. The patient again received 100,000 units of penicillin and was discharged to duty on December 12, 1944. Three days later a routine blood Kahn test was positive and he was transferred for admission to this hospital.

According to the patient's record, routine blood Kahn tests were negative on July 13, 1944, and August 19, 1944.

Physical examination showed a rupture of the frenulum of the penis at its mid-portion. A shallow, indurated ulcer was seen at either side of the laceration. The lesions were not excavated or painful, and the bases consisted of clean granulation tissue. No other cutaneous or mucous membrane lesions were present. Except for the universal enlargement of the peripheral lymphatic glands, the general physical examination was otherwise essentially negative.

A complete blood count and urinalysis were within normal limits. The blood sedimentation rate (Cutler) was 11 mm. per hour. The blood Kahn test was positive on two occasions. Repeated darkfield examinations of the penile lesions failed to show the presence of spirocheta pallida. They were demonstrated in a material obtained by the puncture of the right inguinal lymph glands. A spinal fluid examination was completely negative.

Penicillin therapy was instituted on December 21, 1944, and a total dose of 2,400,000 Oxford units was

given. There was some swelling and tenderness of the penile lesions during the first twelve hours. No other reactions were noted and the penile ulcers were healed on the fourth treatment day. The blood Kahn test taken on the day after completion of treatment was positive.

Summary

Three cases in which a diagnosis of early syphilis was made following the treatment of gonorrheal urethritis with penicillin are reported. It is probable that both infections were contracted simultaneously. In Cases 1 and 2 the intramuscular injection of 100,000 units of penicillin did not prevent the development of secondary and primary syphilides, four months and five weeks respectively, after the last sexual contact. In Case 3, the same dose of penicillin failed to produce healing of penile lesions (delayed primary or late nodulo-ulcerative secondary syphilides.) A second course 100,000 units of penicillin administered six days prior to admission also failed to heal the penile lesions or to sterilize the regional lymphatic nodes.

In all instances the treatment of gonorrheal urethritis with syphilologically inadequate doses of penicillin suppressed or delayed early clinical manifestations of syphilis. There was no influence exerted upon the normal development of the blood serologic reaction with the possible exception of Case 2. All cases responded satisfactorily to the further administration of penicillin.

It is surprising that there has not been an even more marked suppression of signs and symptoms in cases of unrecognized early syphilis which have received therapeutically small doses of penicillin for the treatment of other conditions. Perhaps those cases which have been detected are the exception and that many will not be recognized until years later when symptoms of cardio-vascular syphilis, central nervous system syphilis, or other late manifestations of the disease, will be the first indication of an infection of long duration.

By preventing such suppression, therapeutically adequate doses of penicillin if given in all instances where pre-clinical, early syphilis is a possibility would not only protect the future of the individual but would also be a safeguard against transference of the disease during its infectious and infectious relapsing stages.

Conclusions

1. Penicillin may suppress or delay the appearance of early syphilitic manifestations when it is given in therapeutically inadequate dosage.

2. Small doses of penicillin administered to persons with undiagnosed early syphilis may delay the diagnosis indefinitely without preventing the development of infectious lesions.

3. It may or may not influence the normal development of the blood serologic reaction for syphilis.

4. The possibility of producing a penicillin resistant syphilitic infection should be borne in mind.[2]

5. The possibility of the presence of syphilis should be eliminated in all cases where the administration of small doses of penicillin are contemplated.

6. All cases of gonorrhea or other venereal diseases which have received less than 1,200,000 Oxford units of penicillin should receive a careful physical examination and a blood serologic test for syphilis once a month for one year or at least once monthly for three months and every three months for one year. A spinal fluid examination should be made between the sixth and the twelfth month.

7. The routine administration of 1,200,000 or more Oxford units of penicillin to all cases of gonorrheal urethritis even though there may be no past history or present signs or symptoms of syphilis is worthy of consideration. In such an event, an adequate follow-up system such as is carried out following the completion of treatment in diagnosed cases of early syphilis would be indicated.

Bibliography

1. Canizares, O.: Penicillin in treatment of simultaneous infections of syphilis and gonorrhea. Arch. Dermat. & Syph., 50:246, (Oct.) 1944.
2. Dunham, W. B.: Hambre, D. M., and Rake, G.: Development of penicillin-fast strain of treponema pallidum. Abst. J. Bact., 47:428, (May) 1944.
3. Hailey, H. E.: Suppression of syphilis by penicillin therapy of gonorrhea. Arch. Dermat. & Syph., 50:269, (Oct.) 1944.
4. Shafer, B., and Zakon, S. J.: Early syphilis masked and delayed by penicillin in the treatment of gonorrhea. Arch. Dermat. & Syph., 50:200, (Sept.) 1944.
5. Van Slyke, C. J.: Miscellaneous Note. J. A.M.A., 126:110, (Sept. 9) 1944.

MSMS

Sir Joshua Reynolds (1723-1792).—It is the year 1789. Reynolds, finishing a portrait of Lady Beauchamp, is suddenly annoyed by a dimness in his left eye. Rubbing does not remove it and he must leave off work. Within ten weeks, the sight of the eye is entirely gone, and he must give up painting permanently. Though Reynolds has up to this time been practically free from physical disabilities, he accepts this calamity calmly and even cheerfully. A grave liver derangement, diagnosed too late, was the cause of his death three years later. —Warner's *Calendar of Medical History.*

Tidal Irrigation Following Gynecological Operations

By Howard H. Cummings, M.D., and
Rigdon K. Ratliff, M.D.
Ann Arbor, Michigan

ABSOLUTE bladder drainage following plastic operations involving the female bladder and lower genital tract is of primary importance. Continuous and adequate bladder drainage in conjunction with aseptic techniques, posture, and chemotherapy, has made the repair of vesicovaginal fistulae, the correction of urinary incontinence, and the lesser traumatic lesions of the pelvic organs more certain curative procedures.

Following gynecological plastic operations, retention of urine and dysuria are frequent postoperative complications. The normal reflex mechanism of micturition is disturbed by changes in the position of the bladder and urethra. Also the associated pain and discomfort following operations for urinary incontinence, cystocele, procidentia of the uterus, and even perineorrhaphies interfere with urination. Residual urine and marked overdistention of the bladder when relieved by frequent catheterization predispose to urinary infections which may menace not only the successful outcome of plastic operative procedures but also the health of the patient.

Today most civilian hospitals are understaffed with nurses and overloaded with patients. Available trained nurses in these institutions are assigned to the seriously ill, surgical and medical cases. Because of these conditions in our hospitals any device that will lessen the need of nursing care is of great value. With this in mind, one of us (R.K.R.) has developed a simple and inexpensive automatic bladder irrigator which during the past three years has served with entire satisfaction (Fig. 1).

The apparatus works on the principle of the siphon and does not differ in this respect from several other devices, for example, those of Monroe[1] and Webb.[2] It serves effectually in any normal bladder and if desired it can serve also as a cystometer.

The apparatus is shown in the accompanying drawing which is practically self-explanatory. Examination of the diagrams shows that it utilizes materials available in most hospitals or at any supply house. As shown in the illustration, the apparatus is assembled by using the following: discarded Baxter Laboratories bottles—two-liter-graduated-intravenous solution containers, one glass Y-tube, one U-tube, one T-tube, one Murphy drip connector, one twelve-inch length of glass tubing, one Hoffman clamp, one Burrett clamp, one discarded R.B.C. capillary pipette (stem only), one ordinary hospital standard, and rubber tubing of one-fourth-inch caliber connecting the various parts. Excepting for the standard, an outlay of not more than two dollars will provide the apparatus.

The catheter used, though not a part of the apparatus, is an integral part of the system, and we consider its choice very important. At best a catheter is a foreign body and any choice which lessens irritation is acceptable. Consequently, a catheter which is easily introduced, securely retained, and easily removed is the catheter of choice. We believe the No. 18 F. Foley bag catheter to be far superior to the de Pezzer, Malecot, or Robinson catheter.

At the completion of a plastic procedure a No. 18 F. Foley bag catheter is passed and inflated. The catheter is closed by means of a Hoffman clamp and covered with sterile gauze held in place by means of a rubber band. When the patient has been returned to her bed the gauze and clamp are removed and the catheter attached to the sterile tidal irrigator.

The irrigator, minus bottles, is assembled as illustrated, sterilized, and stored as a sterile bundle. At the bedside the reservoir bottle of sterile normal saline solution and the sterile drainage bottle are attached. In the completed setup, the one fixed part is the inverted T-tube, the top of which is at bladder level or approximately 4 cm. below the symphysis pubis. When the patient has recovered from anaesthesia and when the base of the inverted U-tube stands at fifteen cm. above the level of the top of the inverted T-tube, water is allowed to run slowly into the bladder, displacing all air from bladder and system. Approximately 300 c.c. of fluid will be required to fill the bladder

and system before siphonage is initiated through a fifteen c.c. column of water—the heighth of the U-tube above the T-tube. Should the patient complain of fullness before siphonage is initiated the catheter may be left in the bladder for ten days or more.

Most of our patients remain on irrigation for eight days. In our experience four doses daily of

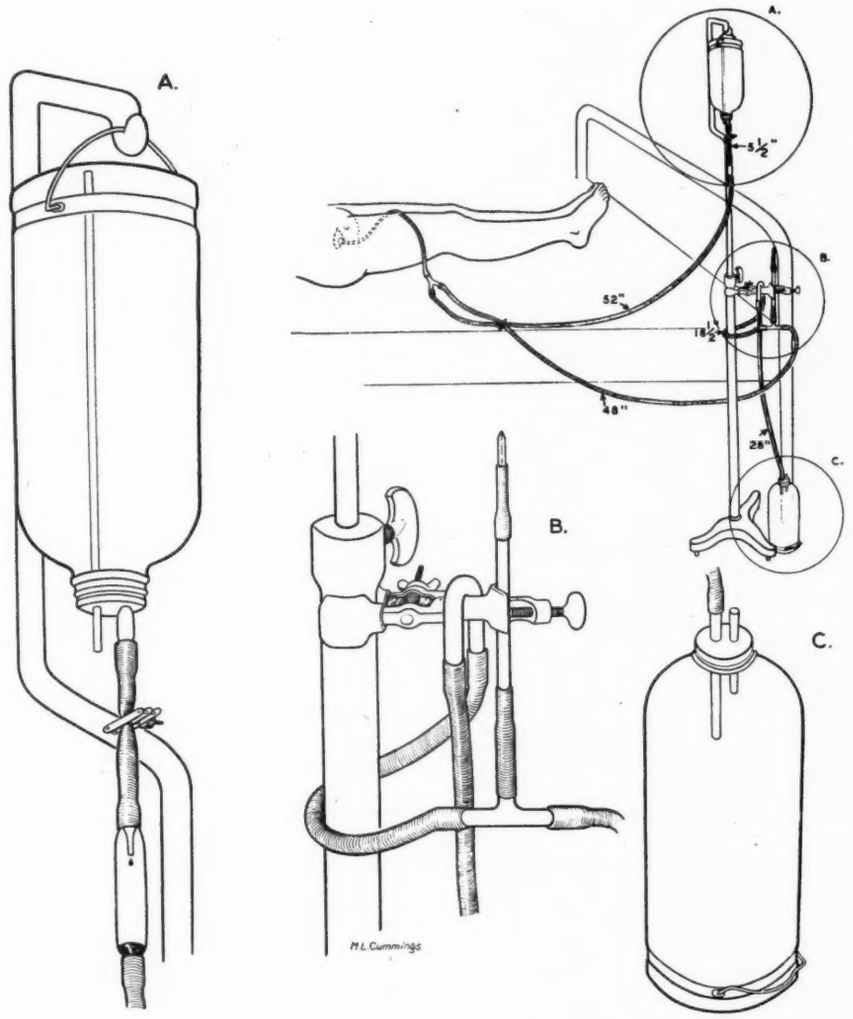

Fig. 1. Diagram of automatic bladder irrigator.

U-tube can be lowered. When the bladder is emptied, suction is stopped by air entering the system through the capillary pipette. The irrigant is adjusted by means of the Hoffman clamp at 60 gtts. per minute. This, plus the rate of urinary output, determines the tidal frequency or irrigation frequency.

Our experience with this type of bladder irrigator has been rather extensive. We have found that its cheapness permits a hospital to have sets of the apparatus sufficient for all patients needing it. When properly set up and adjusted, the apparatus requires no further care except that of refilling the normal saline containers, and the seven and one-half grams of sulfadiazine given at intervals of four hours will maintain a sterile urine throughout the operative convalescence. A few patients, most of whom are of the nervous type, complain of urgency. As a rule, this discomfort can easily be relieved by a mixture of tincture of hyoscyamus and potassium citrate. However, a few with very irritable bladders will not tolerate a catheter in the bladder, and in these patients the apparatus cannot be used. About 98 per cent of our cases were entirely comfortable during their convalescence. In all of these respects we have found the apparatus to be highly satisfactory: the

(Continued on Page 410)

Editorial

1946 DUES NOW PAYABLE

THIS is a reminder to all members who have not yet paid their 1946 dues. The County Secretary is as busy as you and has no time to send out individual statements. Such notices also use needed paper and postage. Your prompt check to the County Secretary will save time and expense as well as clerical effort. The dead line is March 31, 1946.

If each member whose dues and assessments are not yet paid will remit promptly, the work of the Society will go forward. It is not necessary to enumerate the advantages of paid-up membership, but it is a satisfaction to enjoy them.

DUES AND ASSESSMENTS

WHY THE 1946 special assessment? and what is it being used for? What do we get out of the dues we have to pay to the medical societies?" These are some of the questions being asked and answered all over the state. Surprisingly enough the one about the large assessment is asked most often from the region near the center which proposed it.

Medicine is a trade according to the United States Supreme Court, but if it were a union we would have to pay an initiation fee of seventy-five to a hundred dollars to get in, and five dollars or more a month to keep in. That would not include special assessments.

We have had about 40 per cent of our doctors in the military services for from one to five years. They were the younger and more vigorous members, the ones who would gladly pay dues, but their dues have been suspended for the period of their service, and a year after their return. It is estimated that has already cost the society over eighty thousand dollars. We have had two special assessments which have partly made up for the loss, but these assessments were earmarked for special use—public relations.

The medical profession has been woefully weak in public relations, as indicated by the many threats against our very existence, by threats to socialize us, by the EMIC program forced on us against our wills but which we were forced to accept or suffer the charge of being unpatriotic. Good public relations might have foreseen these threats and warded them off.

We have used the radio in Michigan as a force to help our programs. We have now engaged a public relations counsellor, as ordered by the House of Delegates, to extend our activities. The House of Delegates spread a special assessment of twenty-five dollars on each member for the year 1946, and told The Council how to spend it.

An appropriation has been made for continuing the Radio, for newspaper publicity, for a public relations counsellor and his staff, for the Michigan Health Council, for Michigan's share in the work of the Conference of Presidents and other officers in promoting a program of service and of National health legislation that could be enacted into law and to which the profession can give its unstinted support. We are to educate the public on the true implications of unwise legislation, and promote a plan for service that will be much more efficient, vastly less costly, promote individuality, and preserve our profession.

The Michigan State Medical Society has a tremendous job to do in the year 1946. It must be financed. We urge all members who have not already done so to send in their dues and assessments to the County Society Secretary. Under regulations and the rulings of the U. S. Postoffice Department, dues (Subscriptions) must be paid by April 1, or the member is not in good standing.

NATIONAL HEALTH ACT OF 1946

WHAT COULD well be the title of a bill to be enacted by the National Congress. Will it be the so-called Truman Compulsory Health Insurance proposal, being sponsored by Wagner, Murray, and Dingell but which is really the brain child of a group of international labor agitators who are trying to promote socialism in this country as well as in some others? Or will it be the plan proposed by the Conference of President and Other Officers State Medical Societies reported in the December JMSMS and republished in subsequent numbers?

We are again publishing this resolution (page 292) which sets forth a program for health service that would be beneficial to the people; one that

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Teaching of Medical Economics in Medical Schools

Up to a few years ago the doctor was pretty much of an individualist when it came to matters of medical economics. In his practice he came to know who could pay for his services, and those who could not. He also knew who were on the borderland and adjusted his fees accordingly. If a sick person became a public charge there usually was some local arrangement whereby he was well cared for even if the attending physician got little or nothing for his services.

With changing trends the medical profession has become conscious of the need for more specific plans for the financing of unexpected illness and has gone a long way in leadership to provide workable methods of combatting the uncertainties of sickness. On the other hand it does not accept the responsibility for the economic ills of this country, nor does it wish to fall under the spell of the philosophy of legislated health for that would mean bureaucratic control of our future activities. The doctor must still be the master of his own destiny, and be ever mindful of what is best for his public. He must accept the challenge that lies before him now and familiarize himself with matters of health economics in addition to the vast wealth of scientific knowledge he must acquire. The people are demanding security from catastrophic illness, and rightfully so, and your officers of this State Society have taken the attitude that it is better for all concerned if such security can be attained on a voluntary basis rather than by any system of compulsion.

During the past war years our medical schools have had considerable experience with government control, and most of them will be glad to abandon the streamlining of their courses, and return to their former curriculums. They also realize the present need of teaching economics to members of the senior classes, and I am glad to report that considerable progress has been made with the faculties of the medical schools of this state in co-operation with a committee of The Council of the Michigan State Medical Society to initiate such a teaching program. Lectures will start early enough so that the classes scheduled to graduate during the spring months will be covered. This is a splendid gesture on the part of our medical schools, for it opens the opportunity for the medical society to present the economic ideas of practitioners who are in the open field of service, representing the experiences and needs of the average doctor who makes up the bulk of the State Society. Of the activities of the latter body the student may well acquaint himself for it is the one organization he will want to affiliate with first on completion of his period of training. This program must not be allowed to lag or fall into discard, for it is the intent of your Medical Society and the Medical Schools to secure the utmost benefit from such a program of instruction.

President, Michigan State Medical Society

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President's

Page

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NATIONAL HEALTH ACT OF 1946

(Continued from Page 358)

would cost a mere fraction of the international socialistic scheme.

The matter of cost of national health insurance is worthy of comment. In England where a plan has been in operation for many years it has been found necessary to employ one clerk for every one hundred persons insured, but one doctor for every 1,184 (City of Sheffield). Think what that would mean in this country! There would be upwards of one and a half million federal, state, and local employes to police the sickness insurance system! That gives some idea of the administrative overhead, when it takes twelve employes for each doctor rendering the services. Is it any wonder that 84 per cent of the money goes for administrative overhead?

President Truman reiterated the implication that the private practice of medicine was responsible for the fact that 35 per cent of those examined by selective service were rejected, and proposed compulsory health insurance to cure that defect. Not arguing the gross inaccuracy and patent injustice of his figures, how does he account for England's over 60 per cent of rejections with lower standards than America's Selective Service and thirty years of compulsory sickness insurance?

YOUR STATE DOCTOR

THE JOURNAL of the Tennessee State Medical Association for January, 1946, quotes from an editorial in the *London Daily Sketch,* November 10, 1945:

". . . each of us has a deeply rooted affection for and confidence in our own family doctor. The New Minister of Health scoffs at this idea as nonsensical. According to his ruling, any doctor, so long as he is an approved servant of the State, is good enough for you. . . .

"In his new Hospital Bill, the whole of the medical services of the country will be brought under his control and direction. He will not even trouble to have any prior consultations with the hospitals, the local authorities, or the medical profession. . . . All the voluntary and local authority hospitals will be brought by it under state control. A civil servant appointed by Mr. Bevan WILL INSTRUCT AND COMPEL DOCTORS to work in specified areas. . . .

"Mr. Bevan, with the help of the taxpayers' money may provide buildings, and he certainly will be able to provide some sort of doctors, many of them no doubt very efficient. But if doctors are to be paid not by their patients, but out of public funds, as is the intention, and the amount they receive is to depend not upon the nature of the case and the amount of attention they give to it, but the number of people they are responsible for, he will be substituting that quick, cursory, and dubious panel system so much under suspicion for haste and humbug, for the infallible prescription of personal confidence in one's own selected practitioner. Feudalism at its worst never indulged in such tyrannical folly as this."—*London Daily Sketch.*

A. J. Altmeyer, Chairman, Social Security Board in this JOURNAL, December, 1945 (page 6 of colored insert) says:

"As you know, The British Medical Association, as a result of over thirty years of experience with health insurance, is wholeheartedly in favor of the principle of compulsory health insurance. Indeed, it has assumed leadership in demanding that the present health insurance system be made more comprehensive in terms of persons covered and services rendered."

Which one lied? Mr. Altmeyer or the *London Daily Sketch?*

ON THE RUN . . .

The danger of overinvestigation is likely to grow in an organized medical service, and in an insured population entitled to benefit and compensation.

• • •

. . . Symptoms in causalgia are related to an injury to sympathetic nerve fibers and may be relieved by sympathectomy.

• • •

. . . In ruptured intervertebral disk, many patients recover with rest, leg traction, and back support.

• • •

. . . Carcinoma is likeliest to metastasize in bone from the prostate, breast, thyroid and kidney.

• • •

. . . The extensive association between head injury and psychiatric factors indicates possibilities for lessening disability by psychiatric treatment.

• • •

Cardiac output in the recumbent position is increased by about 25 per cent, counterbalancing the gain from lowered metabolism, heart rate and blood pressure.

MSMS

ANAL CRYPTITIS

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ing which would leave pockets underneath the healed surface. In dealing with the sphincter several points are worthy of emphasis. Cut the sphincter at only one place at a time, cut the sphincter at right angles to its fibers and do not pack between the ends more than forty-eight hours.

The importance of cryptitis is not apt to be overemphasized. It is a rather insidious disease to which attention is usually directed because of the complications which develop. Infected crypts and ducts should be considered as the possible cause of diseases both local and general.

6 North Michigan Avenue,
Chicago 2, Illinois

Proceedings of Annual Session of the Council

Detroit, January 18-19, 1946

All twenty-one members of The Council, except A. H. Miller, M.D. of Gladstone, whose mother was seriously ill, were present for the 1946 mid-winter meeting held at the Wardell-Sheraton Hotel, Detroit, on January 17, 18 and 19.

Annual Reports Presented

The Council heard the annual reports of the Secretary, Treasurer, Trustee, and Editor. Reports were presented by the three standing committees and six special committees of The Council. Other reports included those of the MSMS Committees on Cancer, Postgraduate Medical Education, Public Relations and Rheumatic Fever Control. T. K. Gruber, M.D., Eloise, reported for the Michigan Delegates on the recent American Medical Association House of Delegates.

Committee Appointments

President R. S. Morrish announced the following additions and changes in personnel of MSMS Committees which were confirmed by The Council:

R. S. Breakey, M.D., Lansing, as Chairman of Joint Committee with State Bar of Michigan relative to Venereal Disease Control.

John Towey, M.D., Powers, as Chairman of Tuberculosis Control Committee.

Arthur C. Curtis, M.D., Ann Arbor, to Venereal Disease Control Committee.

James D. Bruce, M.D., Ann Arbor, was made Chairman Emeritus of the MSMS Committee on Postgraduate Medical Education.

H. H. Cummings, M.D., Ann Arbor, was appointed as Chairman of the Postgraduate Medical Education Committee.

O. O. Beck, M.D., Birmingham, was nominated as the sixth representative from the medical profession to the Board of Directors of Michigan Hospital Service.

The 1945 report of the auditors (Ernst & Ernst) was presented, thoroughly studied and approved.

The detailed budgets for 1946 were developed and approved.

Michigan Medical Service

R. L. Novy, M.D., Detroit, President of Michigan Medical Service, gave a progress report on the sound financial condition of Michigan Medical Service as of January 1, 1946. He reported that the Service is disbursing $400,000 per month for health services; that during 1945 a total of $4,149,000 was so disbursed, and since the inception of Michigan Medical Service a total of $13,634,208.25 has been paid. **This represents approximately 88 per cent of income for the provision of services to subscribers. Administration costs are approximately 11 per cent. The subscribers maximum total was 877,000, since slightly decreased on account of strikes to 858,000.**

The Michigan Medical Service has signed a contract with the Veterans Administration to act as fiscal agent between the government and Michigan doctors who desire to render medical care to veterans. Michigan Medical Service has adopted the "Michigan Uniform Fee Schedule for Governmental Agencies" for all its payments.

Elections

L. Fernald Foster, M.D., Bay City, was re-elected Secretary, A. S. Brunk, M.D., Detroit, was re-elected Treasurer and Wilfrid Haughey, M.D., Battle Creek, was re-elected Editor for the coming year. Mr. Wm. J. Burns was reappointed Executive Secretary.

MODERN EVOLUTION

One day two young friends of Charles Darwin decided to play a joke on the great scientist. The boys took the wings of a butterfly, the legs of a grasshopper, the head of a beetle, and the body of a centipede, and very carefully glued these parts together.

Then, placing the manufactured insect in a box, they called on Mr. Darwin.

"Mr. Darwin," they said, "we caught this bug in a field. Can you tell us what it is?"

The scientist examined the insect carefully and then asked, "Did it hum when you caught it?"

"Yes," replied the boys.

"Then," said Darwin, with a twinkle in his eye, "it must be a humbug."—*J. Am. Inst. Homeop.*, Dec., 1945.

SECRETARY'S ANNUAL REPORT, 1945

By L. Fernald Foster, M.D., Bay City

The Michigan State Medical Society membership for 1945, the fourth year of World War II, showed a total of 4,686 members, including forty-six Emeritus, Honorary and Retired members and 1,245 Military members. The total paid memberships were 3,395 with net dues of $35,585.36 accruing to the Society. The number of members with unpaid dues for 1945 was fifty-nine. The membership tabulation for the years 1944 and 1945 showing net gains and losses, unpaid dues and deaths is as follows:

MEMBERSHIP RECORD, 1945

County	1944	1945	Military	Loss	Gain	Unpaid	Deaths
Allegan	19	17	3	2			
Alpena-Alcona-Presque Isle	12	11	6	1			
Barry	10	10	3				
Bay-Arenac-Gladwin-Iosco	49	51	26		2		
Berrien	49	47	10	2		2	
Branch	15	17	8		2	1	
Calhoun	69	67	38	2		1	1
Cass	12	10	2	2		1	
Chippewa-Mackinac	16	14	6	2			1
Clinton	10	10	4				
Delta-Schoolcraft	17	18	5		1		
Dickinson-Iron	16	16	4				1
Eaton	15	14	7	1			1
Genesee	142	136	50	6		2	3
Gogebic	17	16	2	1			
Grand Traverse-Leelanau-Benzie	30	34	12		4		
Gratiot-Isabella-Clare	26	25	12	1			
Hillsdale	20	19	6	1		1	
Houghton-Baraga-Keweenaw	31	28	7	3			
Huron	11	11					
Ingham	128	115	39	13		7	1
Ionia-Montcalm	32	29	10	3			3
Jackson	72	70	28	2			3
Kalamazoo	76	75	41	1		1	4
Kent	181	176	84	5		2	3
Lapeer	12	10	3	2			1
Lenawee	26	25	14	1			
Livingston	14	13	5	1			
Luce	7	5	3	2		1	
Macomb	28	26	11	2		1	2
Manistee	8	9	2		1		
Marquette-Alger	28	28	8			1	1
Mason	7	7	4				
Mecosta-Osceola-Lake	12	9	3	3		3	
Med. Soc. of No. Cen. Cos.	12	12	3				
Menominee	9	11			2		
Midland	15	15	2				
Monroe	26	29	11		3		1
Muskegon	63	62	17	1			3
Newaygo	9	7	1	2			
Northern Michigan	28	24	6	4			
Oakland	114	112	42	2		2	3
Oceana	9	8	3	1			
Ontonagon	4	3		1			1
Ottawa	22	22	9				
Saginaw	68	62	33	6			1
Sanilac	11	10	3	1			
Shiawassee	14	13	8	1		1	1
St. Clair	46	44	7	2			2
St. Joseph	14	16	10		2		
Tuscola	21	13	5	8		6	
Van Buren	20	20	10				2
Washtenaw	157	144	64	13		4	3
Wayne	1,596	1,583	539	13		22	26
Wexford-Missaukee	18	17	6	1			1
	3,493	3,395	1,245*	115	17	59	69

* This total of 1,245 Military Members includes eight who died in the Service.

Deaths During 1945

We regretfully record the deaths of the following sixty-nine members during 1945, including eight who died in military service.

Calhoun County—Royal M. Walters, M.D., Battle Creek.
Chippewa-Mackinac County—E. H. Webster, M.D., Sault Ste. Marie.
Dickinson-Iron County—E. B. Andersen, M.D., Iron Mountain.
Eaton County—Phil H. Quick, M.D., Olivet.
Genesee County—John W. Handy, M.D., Flint; Guy C. Matthewson, M.D., Flint; Frederick B. Miner, M.D., Flint.
Ingham County—Harry A. Haze, M.D., Lansing.
Ionia-Montcalm County—*Arthur L. Benison, M.D., Edmore; F. H. Ferguson, M.D., Carson City; F. M. Marsh, M.D., Ionia.
Jackson County—R. W. Chivers, M.D., Jackson; *W. R. Finton, M.D., Jackson; E. G. Wilson, M.D., Jackson.
Kalamazoo County—R. S. Harter, M.D., Schoolcraft; Gordon B. Moffat, M.D., Kalamazoo; *Charles E. Osborne, M.D., Vicksburg; Benjamin A. Shepard, M.D., Oshtemo.
Kent County—Clarence H. Barber, M.D., Grand Rapids; Carl F. Snapp, M.D., Grand Rapids; Rowland Webb, M.D., Grand Rapids.
Lapeer County—Merton O. Blakeslee, M.D., Lapeer.
Macomb County—Henry G. Berry, M.D., Mt. Clemens; R. E. Hawley, M.D., St. Clair Shores.
Marquette-Alger County—Vivian H. Vandeventer, M.D., Ishpeming.
Monroe County—J. J. Siffer, M.D., Monroe.
Muskegon County—Ernest D'Alcorn, M.D., Muskegon; S. A. Jackson, M.D., Muskegon; R. G. Olson, M.D., Muskegon.
Oakland County—Frank D. German, M.D., Pontiac; Morrell M. Jones, M.D., Drayton Plains; *Francis Needle, M.D., Pontiac.
Ontonagon County—W. J. Pinkerton, M.D., Ramsay, Michigan.
Saginaw County—J. G. Maurer, M.D., Saginaw
St. Clair County—J. M. Atkinson, M.D., Port Huron; A. L. Zemmer, M.D., Port Huron.
Shiawassee County—George L. G. Cramer, M.D., Owosso.
Van Buren County—J. K. Jamieson, M.D., Paw Paw; Edwin G. Low, M.D., Bangor.

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ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its slower *and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:

- **The man who finds it necessary to stop and rest when he walks to the train in the morning.**
- **The man who suffers "indigestion" and "gas" on exertion, or after a heavy meal.**
- **The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.**

ERYTHROL TETRANITRATE MERCK
(Erythrityl Tetranitrate)

For Prolonged Vasodilatation

COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION ACCEPTED

MERCK & CO., Inc. *Manufacturing Chemists* **RAHWAY, N. J.**

SECRETARY'S ANNUAL REPORT

(Continued from Page 368)

Washtenaw County—J. F. Breakey, M.D., Ann Arbor; Neil A. Gates, M.D., Ann Arbor; Charles B. Pillsbury, M.D., Ypsilanti.

Wayne County—Jay M. Burgess, M.D. Detroit; Basil L. Connelly, M.D., Detroit; Henry R. Craig, M.D., Eloise; Thomas B. Cooley, M.D., Detroit; *Donald Douglas, M.D., Detroit; George E. Fay, M.D., Detroit; *William D. Frostic, M.D., A. A. Gronow, M.D., Detroit; Stewart Hamilton, M.D., Detroit; Lawrence N. Host, M.D., Detroit; Alpheus F. Jennings, M.D., Detroit; Joseph J. Jonikaitis, M.D., Detroit; Jacob Manting, M.D., Detroit; Vernon S. Lilly, M.D., Detroit; Charles E. McMehen, M.D., Detroit; Edward R. Ridley, M.D., Detroit; Harold F. Sawyer, M.D., Detroit; William J. Seymour, M.D., Detroit; Frank Spencer, M.D., Detroit; Harry F. Stamos, M.D., Detroit; Colletta M. Swaney, M.D., Detroit; H. N. Torrey, M.D., Detroit; William G. Wander, M.D., Detroit; John P. Watkins, M.D., Detroit; *F. L. Watters, M.D., Detroit; *John H. Wax, M.D., Detroit.

Wexford County—John F. Gruber, M.D., Cadillac.

*Died in Military Service.

Financial Status

The books of the Michigan State Medical Society were audited on December 28, 1945, by Ernst & Ernst.

Their published report reveals the following financial conditions: Assets are listed at $123,299.18, and are $25,181.22 more than a year ago. The net worth is $61,460.27 compared to $43,603.13 in 1944. The income from dues was $35,589.86 with a JOURNAL income of $7,695.21, interest of $1,727.90 and miscellaneous receipts of $17,544.45 (repayment by Michigan Medical Service of funds advanced in 1939 and 1940) or a total income of $62,557.42, an increase of $16,956.35 over 1944.

The Society expenses totaled $44,656.53.

The security portfolio consists of high grade bonds, approximately 50 per cent of which are in U. S. Savings and War Bonds. The securities on December 28 totaled $75,270.69, represented as follows:

Securities held by the society	$53,612.25
Securities held by the Postgraduate Medical Education Foundation	21,658.44

Interest received on securities during the year was $1,914.37.

The Postgraduate Medical Education Foundation fund shows a balance on December 28 of $23,400.86 as compared with $18,210.56 one year ago. This increase was due largely to contributions received from the Andrew P. Biddle estate and recent contributions.

The Public Education Fund created by the $10.00 assessment per member amounted to $33,875.00. The balance in this fund on December 28 was $12,150.00.

The JOURNAL had allocated to it from members' dues $5,084.14. Other incomes were from subscriptions, reprint sales, advertising sales, and JOURNAL cuts, making a total income of $45,823.72. The expenses included the salaries and expense amounting to $8,400.00, printing and mailing, $19,241.36, and these with other relatively small expenses made a total of $38,128.51. The income was $7,695.21 over expenses.

Medical Defense Funds showed a balance on December 30, 1944, of $3,301.90. Interest in the amount of $195.00 accrued during the year, making a total of $3,496.90 on December 28, 1945.

At the 1944 House of Delegates, there was ordered a $5.00 assessment on each member for a Veterans' Readjustment Program. This was to provide services to the returning medical veteran in matters of Location, Postgraduate Education and Finance. It later developed that these services could best be established at the County level and through already existing agencies within the State Society. As a result The Council decided to return these funds to the county societies in the amounts as collected. The total amount returned to the county units was $16,871.25.

Summary.—The financial statement of the auditors is complete in every detail of the Society's wartime position. With approximately 1,245 members in the armed forces the impact of war in this one instance reflects, through the remission of dues, a loss of income of nearly $15,000.00 per annum.

The 1945 House of Delegates

Due to travel and convention restrictions of the Office of Defense Transportation, no General Assembly was held in 1945. The House of Delegates, however, convened in regular session on September 17-18, at the Book-Cadillac Hotel, Detroit, and conducted the usual transactions of that body.

County Secretaries' Conference

Since no General Assembly was held in September, the usual Secretaries' Conference was not held at that time. A very successful Secretaries' and Public Relations Conference was held in Detroit on January 28, 1945. This conference was attended by over 180 registrants and its discussions were devoted to the subjects of the "Public Relations Program for the Medical Profession." "Proposed Amendment to Constitution of Michigan"; and the "Physical Rehabilitation Program of the Federal Government."

Committees

Committee activities were maintained at an unusually high level during 1945 despite the fact the travel restrictions were in effect most of the year. A perusal of the various committee activities as published from time to time will attest to the fact that the many long-range committee programs have been maintained, with unusual efficiency.

Society Activities

During 1945, officer contact with the 55 County units was considerably restricted. Nevertheless, practically every society was contacted personally by its councilor or some one of the administrative personnel.

Dissemination of society activity news was maintained throughout the year by the issuance of Secretary letters. Beginning in 1945 the monthly Secretary's Letter was sent not only to Presidents, Secretaries, and Editors of County Medical Societies but also to all members of the MSMS House of Delegates and of The Council. Eight of these were sent during the past year, and three went to every member of the Society.

With a cessation of hostilities on the war fronts in 1945, there has been a steady return of medical veterans

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SECRETARY'S ANNUAL REPORT

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to their civilian practices. We record with pride the honor roll of 2,287 Michigan doctors of medicine serving with the armed forces. With equal joy we now record the return of many of these same physicians.

The State Society has been untiring in its efforts to aid in the solution of the many problems confronting our returning medical colleagues. Every aid has been given especially in matters of location and postgraduate and review courses. Latest reports from the Committee on Postgraduate Medical Education indicates the popularity of provided courses for Medical Veterans is taxing to the limit the teaching facilities of our two medical colleges.

All of the administrative and organizational units of the State Society have worked zealously during 1945 to develop plans and devices to aid in the solution of the inevitable postwar economic and social problems of the medical profession. In their efforts they have been generously supported by the House of Delegates which provided adequate funds for the development of a modern Public Relations program.

It would be too time-consuming to attempt to describe in detail the many progressive activities that have been initiated by your Soicety in the short space of a few years. Your State Society has acquired a national reputation for the development of original and progressive programs in the field of scientific medicine and socio-economics.

Your attention is respectifully invited to a list of what has come to be known as "Michigan Firsts"—fourteen in number as follows:

1. Established Michigan Medical Service—the first professionally sponsored voluntary Medical Care plan. Now with nearly 1,000,000 subscribers the largest in the world.

2. Developed a Uniform Fee Schedule for Governmental Agencies thereby establishing a minimal intrinsic value of medical services.

3. Contracted with The Veterans Administration to render home-office medical care to Veterans in their home communities by their own family doctor. The contract utilized the Uniform Fee Schedule for Governmental Agencies and the services of Michigan Medical Service. It was the first statewide plan approved by the Veterans Administration.

4. Provided postgraduate education for doctors in their home communities by a unique plan of extra-mural courses.

5. Created the Michigan Foundation for Medical and Health Education—contributions to which now approximate $100,000.00.

6. Instituted an annual Industrial Health Conference. A conference designed to bring to industrial surgeons and medical men in general the latest advances in Industrial Health and to develop a better understanding between the general practitioner and the specialist in Industrial Medicine and Surgery.

7. Established a Michigan Rheumatic Fever Control program with nine diagnostic and consultation centers throughout the State. The first of such to be controlled and operated by a State Medical Society and practicing physicians.

8. Provided Cancer Control Clinics and published an outstanding "Cancer Manual" through the efforts of the Cancer Control Committee.

9. Organized the Michigan Health Council in cooperation with the Michigan Hospital Association, the Michigan Medical Service and the Michigan Hospital Service.

10. Pioneered in the development of a commercial radio program by a State Medical Society and to date has provided four series of weekly presentations on a paid basis.

11. Inaugurated a conference of State Medical Society Presidents. The original gathering of seventeen Presidents in Detroit in April, 1945, culminated in the formation of a permanent organization in December, 1945, with representation from forty-two State Medical Societies. Our own immediate Past-President, Dr. A. S. Brunk, who conceived the idea, is serving as President of the organization.

12. Developed an "Outline" for needed medical legislation by a Drafting Committee on Legislation, for submission to governmental agencies by and through State Medical Societies and the A.M.A. Council on Medical Service and Public Relations.

13. Stimulated activity for the creation of a "National Health Congress" to co-ordinate and encourage efforts along socio-economic lines by state medical societies, state dental societies, state or district hospital associations, state or district pharmaceutical associations, and the other groups interested in maintenance of the voluntary type of medical service.

14. Created a Medical Veterans Readjustment Program to aid the returning veterans in matters of postgraduate education and relocation.

Your State Society's activities especially in the field of socio-enconomics has attracted, as would be expected, national attention. This attention has come not only from other State Societies, but from agencies of government at the national level. Since the parent organization of the medical profession, the American Medical Association, insists on maintaining the status of a Scientific and Educational organization, it is apparent that such a status precludes any participation in the field of medical economics. Obviously there should be some potent organization that can and will assert a practical influence in matters of medical economics on a national basis. The recent contacts made with your State Society by several important Federal groups indicates that the society has a recognized capacity of leadership and a definite responsibility both to the physicians of Michigan and to medicine in general.

The only organization that at the present time emerges as the one capable of developing a program on socio-economics at the national level and one that has not acquired any adverse prejudices is the Conference of Presidents and other Officers of State Medical Associations. This is an organization of your own conception and one which can function throughout the country. In

(Continued on Page 376)

SECRETARY'S ANNUAL REPORT

(Continued from Page 374)

view of these facts, I respectfully submit the following recommendations:

Recommendations

Recommendation: That the Michigan State Medical Society give practical and concrete support to the Conference of Presidents and other Officers of State Medical Associations to the end that it will develop activity in behalf of organized medicine at the national level. Such support will undobtedly enlist similar support from other state societies who need only encouragement and leadership.

Recommendation: In view of the fact that the recently signed contract with the Veterans Bureau for home-office care of veterans may occasion various problems related to that care, and realizing that similar problems may arise in the care of other governmental categories affected by the Uniform Fee Schedule, I further recommend that—The Council consider the appointment of a General Board of Control of Doctors of Medicine to aid the proper interpretation and execution of the Uniform Fee Schedule, this to be augmented by the further establishment of Boards of Control at the county levels.

Your Secretary wishes to express to The Council his sincere appreciation of its splendid co-operation and encouragement and to the committees of the State Society for their vigorous efforts to preserve and enlarge the scientific and economic activities of the society, a hearty commendation.

Mr. Burns and the Executive office personnel have been most untiring in the discharge of their many duties. For their loyal service and co-operation, your Secretary is most grateful.

TREASURER'S ANNUAL REPORT, 1945.

By A. S. Brunk, M.D., Detroit

Market value of bonds in General Account	$14,622.50
United States Savings Bonds carried at maturity value	36,100.00
Total	$50,722.50

In February, 1945, Michigan Medical Service repaid a loan of $17,544.45 to the Michigan State Medical Society. It was decided to purchase United States War Savings Bonds Series G. The purchasing price of these bonds was $17,600 the difference of $55.55 was paid out of the Treaurer's General Fund.

On October 1, the Consolidated Oil Corporation Bond was called for payment at 102. It was felt the best investment at this particular time was United States Savings Bonds. The Executive Committee of The Council approved of this action in October and $1,000 was invested in Government Savings Bonds.

CASH ACCOUNT

General Fund

Balance on hand General Fund, January 1, 1945		$ 418.50
Deposited in Michigan National Bank during 1945		1,936.17
		2,354.67
Withdrawals during 1945		1,055.55
Balance on hand January 16, 1946, in Michigan National Bank		$ 1,299.12

Bonds in General Fund

	Bonds	Interest Rate	Date Due	Quoted Market Price Jan. 16, 1946
I.	2 M Canadian Pacific Railroad	4	Perpetual	$ 2,240.00
	2 M New York Central Railroad	4	1998	1,960.00
	2 M Detroit Edison Company	3½	1966	2,160.00
	1 M Union Pacific Railroad	3½	1970	1,060.00
	1 M United Light and Power	5½	1959	1,050.00
	1 M Grand Rapids Affiliated	5	1955	910.00
	1 M Southern Pacific Railroad	4½	1977	1,050.00
				10,430.00
	Government Savings Bonds carried at full value			36,100.00
				$46,530.00
II.	The following bonds have been called and are no longer interest bearing.			
	1 M Consumers Power Company @ 105¼			1,052.50
	1 M Government of Dominion of Canada @ 104			1,040.00
	2 M American Telephone and Telegraph @ 105			2,100.00
	Total bonds			$50,722.50
	Total cash			1,299.12
	Total amount in Treasurer's account			$52,021.62

EDITOR'S ANNUAL REPORT, 1945

By Wilfrid Haughey, M.D., Battle Creek

The Journal of the Michigan State Medical Society has been published regularly during the year 1945, but has been appearing late most of the time. It has been much larger than before, 1,428 pages excluding the four pages of cover each month, and twenty pages of insert in tint in the December number, giving the papers and report of the Presidents' Conference in Chicago, December 2, 1945. The principle cause for tardiness of The Journal was its increased size, and the large increase in advertising pages, expecially those in color. There have had to be about two and half times the press work on The Journal as would be the case in The Journal as it appeared two or three years ago.

Advertising

The industrial and financial conditions have increased the availability of colored advertising, and in fact of all advertising, and we have profited by taking it. We have used the front pages for advertising, and have interspersed reading material, such as the departments of War Medicine, Political Medicine, Readjustment for Veterans, Medical Public Relations, et cetera, putting about fourteen pages of reading in amongst the advertising. This has made advertising appeal, and has brought to us much advertising that would not otherwise have been ours.

We have been severely criticized for making The Journal "a house organ," but have felt that we have given our members a good grade of interesting and instructive material, which in other journals is grouped in the text in the center of the journal. By our arrangement we have enticed much advertising.

Advertising Policy

While on the subject of advertising we have expanded our plan of accepting advertisements that have not been Council rejected, that are in common use, and that have a local appeal. We have tried in our selections to use only preparations put up by reputable houses, those whose contents seem proper, and those whose advertising is first quality. By this stand we have been able to use many products that would have been rejected had we awaited Council approval. Our advertisements are sent to the Publication Committee and are approved by them by mail before being used.

Original Articles

During the year we have published fifty-eight original articles. They have been of all sizes as to length, but have averaged longer than in the past years. Owing to our meeting having been omitted this year we have had a dearth of articles. We have had sufficient, but

(Continued on Page 380)

EDITOR'S ANNUAL REPORT

(Continued from Page 376)

do not have many on hand. In most instances we have published the picture of the author. We have discontinued the abstract of the paper at its heading.

Editorials, Et Cetera

Sixty-four editorials have been prepared and published this year. Most of them have been on economic or sociological subjects as they relate to medicine and its future. We pride ourselves that we have foreseen and called atention to several trends in medicine that have allowed the Michigan State Medical Society to be way out in front on topics now demanding the attention of the profession: service for the veterans in their homes has been accomplished: a minimum fee schedule for Governmental agencies: a proposed set of principles upon which a national health measure could be built. We have tried to carry out the instructions of the House of Delegates and interpret their actions to the membership.

Doctor's Library

Sixty-six books have been reviewed in our Doctor's Library department. This is less than last year, by almost one-half, but the publication of new books, and new editions has been much curtailed during the war, and especially during the past year. We have tried to make these reviews short but descriptive of our impressions of the book. We have tried to make this department a guide which one could follow in his purchases. There were seventy-one deaths recorded, including eleven in the Military service.

The Journal

The financial report shows THE JOURNAL in the black. We are proud of THE JOURNAL and its record of service.

TRUSTEE'S ANNUAL REPORT, 1945

By Wm. A. Hyland, M.D., Grand Rapids

BONDS IN TRUSTEE FUND

Bonds	*Interest Rate*	*Date Due*	*Quoted Market Price Jan. 16, 1946*
2 M New England Gas & Elec.	5	1950	$ 1,980.00
1 M Southern Pacific Railroad	4½	1977	1,050.00
1 M Grand Rapids Affiliated	5	1955	910.00
			$ 3,940.00

Cash Account

Balance on hand January 1, 1945	$724.40
Collected in interest from January 1, 1945, to January 1, 1946	195.00
Balance on hand in Michigan National Bank	$919.40

ANNUAL COUNTY SECRETARIES CONFERENCE

(Continued from Page 294)

Detroit; John W. Castellucci, Detroit; Gordon Davis, Detroit; Carleton Dean, M.D., Lansing; J. S. DeTar, M.D. Milan; Clarke Dorland, M.D., Lapeer; W. G. Elliott, M.D., Detroit; Rev. John L. Ernst, Detroit; L. Gordon Goodrich, Detroit; R. S. Hainer, Detroit; L. T. Henderson, M.D., Detroit; Henry S. Hosmer, Detroit; Hardy A. Kemp, M.D., Detroit; Jay C. Ketchum, Detroit; David Kliger, M.D., Detroit; Harry Lipson, Detroit; W. G. MacKersie, M.D., Detroit; J. R. McBride, M.D., Lapeer; G. L. McClellan, M.D., Detroit; Martha E. McCrary, Lansing; H. A. Miller, M.D., Lansing; Robert M. Morse, Lansing; R. L. Novy, M.D., Detroit; D. J. O'Brien, M.D., Lapeer; Capt. L. A. Potter, Lansing; Major M. J. Schlussel, M.C., Detroit; C. E. Simpson, M.D., Detroit; A. M. Smith, Detroit; E. J. Steinberger, M.D., Detroit; E. C. Texter, M.D., Detroit; B. H. VanLeuven, M.D., Lansing; John E. Verbiest, Detroit; Roger V. Walker, M.D., Detroit; Arch Walls, M.D., Detroit; Carl G. Wencke, M.D., Battle Creek, and G. H. Wood, M.D., Onaway.

Michigan State Medical Society

BUDGETS, 1946
Adopted by The Council in Annual Session
January 19, 1946
GENERAL FUND

INCOME		
3,200 Members at $12 (dues)		$38,400.00
Less Allocation to JOURNAL ($1.50)		4,800.00
		$33,600
Interest		1,100.00
Miscellaneous		100.00
TOTAL INCOME		$34,800.00
FROM RESERVES		14,420.00
		$49,220.00
APPROPRIATIONS		
Administrative and General		
Administrative Salaries	$ 7,500.00	
Salaries: Office-regular and extra	7,200.00	
General Counsel	2,500.00	
General Counsel Expense	1,000.00	
Office Rent and Light	1,360.00	
Printing, Stationery, Supplies	800.00	
Postage	800.00	
Insurance and Fidelity Bonds	1,650.00	
Auditing	850.00	
New Equipment and Repairs	350.00	
Telephone and Telegraph	1,500.00	
Michigan Sales Tax	100.00	
Payroll Taxes	175.00	
Unemployment Compensation Insurance	785.00	
Miscellaneous General Expense	100.00	
	$26,670.00	
Less Expenses Redistributed to JOURNAL	1,800.00	
TOTAL ADMINISTRATIVE AND GENERAL		$24,870.00
Society Activities		
Council Expense	$ 5,000.00	
Delegates to AMA	2,500.00	
County Secretary Conference	400.00	
General Society Travel Expense	1,750.00	
Officer's Travel	1,750.00	
Secretary's Letter	500.00	
Publication Expense	50.00	
Legal Expense	6,000.00	
Woman's Auxiliary—Annual Meeting	200.00	
Sundry Society Expenses	400.00	
TOTAL SOCIETY EXPENSE		$18,550.00
Committee Expenses		
Legislative	200.00	
Distribution of Medical Care	50.00	
Postgraduate Medical Education	3,500.00	
Preventive Medicine	50.00	
Cancer	500.00	
Child Welfare	50.00	
Iodized Salt	50.00	
Heart and Degenerative Diseases	50.00	
Industrial Health and Clinic	400.00	
Maternal Health	50.00	
Mental Hygiene	50.00	
Scientific Radio	50.00	
Venereal Disease Control	50.00	
Tuberculosis Control	50.00	
Ethics	50.00	
Scientific Work	50.00	
P. and A. S. for M.D.s	50.00	
Prelicensure Medical Education	50.00	
Sundry Other Committees	500.00	
TOTAL COMMITTEE EXPENSE		$ 5,800.00
GRAND TOTAL		$49,220.00

THE JOURNAL, 1946

INCOME		
Subscriptions from members		$ 4,800.00
Other subscriptions		100.00
Advertising Sales		30,600.00
Reprint Sales		1,000.00
JOURNAL Cuts		75.00
TOTAL JOURNAL INCOME		$36,575.00
EXPENSES		
Salaries		$10,440.00
Editor's Expense		1,200.00
Printing and Mailing		16,000.00
Reprint and Cut Expense		900.00
Discounts and Commissions on advertising sales		5,335.00
Allocation of Administration and General Office Exp.		1,800.00
Postage		400.00
Miscellaneous		500.00
TOTAL JOURNAL EXPENSE		$36,575.00

RHEUMATIC FEVER CONTROL
(For 10 months of 1946)

INCOME		
Michigan Crippled Children Society Grant		$15,000.00
EXPENSES		
Headquarters Expense		
Secretarial	$ 1,120.00	
Stationery and Supplies	80.00	
Postage	50.00	
Equipment	250.00	
TOTAL	$ 1,500.00	
Expense for 9 Centers, as above ($1,500x9)	13,500.00	
GRAND TOTAL		$15,000.00

MSMS ANNUAL SESSION, 1946

INCOME		
Booth Sales		$11,300.00
EXPENSES		
Cost of Session	6,985.00	
Salaries	4,140.00	
Reporting Annual Session	175.00	
	$11,300.00	

PUBLIC EDUCATION ACCOUNT, 1946

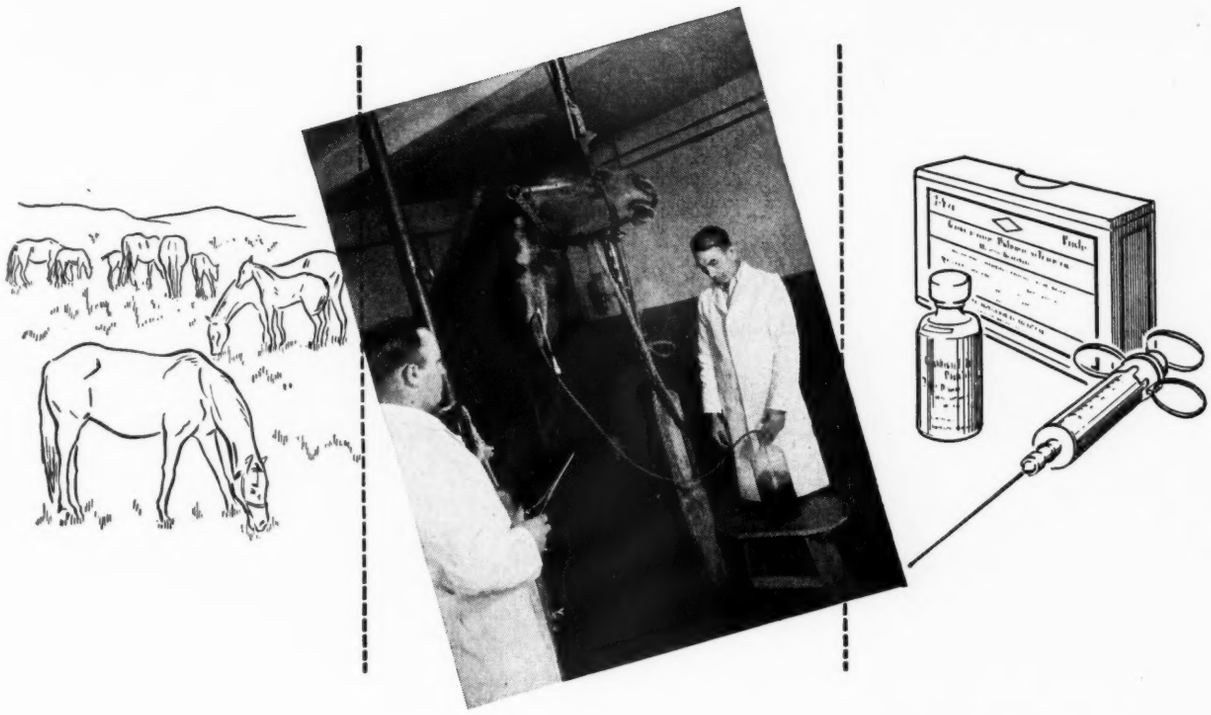
Balance December 28, 1945		$12,150.00
INCOME IN 1946		
3,200 Members at $25.00	80,000.00	
		$92,150.00
EXPENSES		
Salaries	$ 7,000.00	
Office Rent and Light	864.00	
Printing, Stationery and Supplies	1,200.00	
Postage	1,300.00	
Office Equipment	500.00	
Travel Expense	2,000.00	
School of Information (1/20/46)	2,000.00	
Purchase of Pamphlets	2,500.00	
Michigan Health Council	5,000.00	
Public Relations Program:		
Commercial Radio and publicity	27,000.00	
Secondary School Health Education	1,000.00	
Public Relations Conference (2/21/46)	1,000.00	
Newspaper and other media	2,000.00	
Conference of Presidents	5,000.00	
National Conference on Medical Service	500.00	
Special Meetings	500.00	
Miscellaneous	500.00	
Reserve	32,286.00	
TOTAL EXPENSE		$92,150

REPORT OF ERNST & ERNST, 1945

We have examined the balance sheet of the Michigan State Medical Society as of December 28, 1945, and the statements of income and expense and surplus for the period from December 30, 1944, to December 28, 1945, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

The Society was organized on September 17, 1910, under the laws of the State of Michigan as a corporation not for pecuniary profit. The charter was extended on November 10, 1941, for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes the Society publishes "The Journal of the Michigan State Medical Society."

(Continued on Page 386)



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U. S. STANDARD PRODUCTS CO.

BIOLOGICALS

AMPULS AND STERILE SOLUTIONS FOR PARENTERAL ADMINISTRATION

An ideal location in a small rural community favors concentration on the important work in which we specialize—

Patented processes confer distinct therapeutic advantages—

Methods and thinking based upon the advanced frontiers of progress—

—These are factors contributing to the established acceptance of U. S. Standard Products by those of the medical profession who have come to regard them as essential.

U. S. Standard Products are now available at leading pharmacies throughout most of the United States. May we send you detailed information?

OUTSTANDING U. S. STANDARD BIOLOGICALS:

DIPHTHERIA TOXOID
SMALLPOX VACCINE
TETANUS ANTITOXIN
TYPHOID VACCINE

Also a representative list of glandular products and pharmaceuticals.

U. S. STANDARD PRODUCTS CO.

WOODWORTH, WISCONSIN, U. S. A.

(Continued from Page 382)

Balance Sheet

The balance sheet at December 28, 1945, is summarized as follows:

ASSETS Dec. 28, 1945	
Cash	$ 42,808.76
Accounts receivable, less reserve	4,632.36
Securities—at cost	52,457.20
Postgraduate Medical Education Foundation	23,400.86
Deferred charge	.00
	$123,299.18
LIABILITIES	
Accounts payable	$ 11,384.05
Unearned income	14,904.00
Postgraduate Medical Education Foundation—Contra	23,400.86
Reserves	12,150.00
Surplus	16,460.27
	$123,299.18

Income and Expense Statement

A summary of the income and expense statement for the period from December 30, 1944, to December 28, 1945, is presented as follows:

INCOME	
Membership fees	$35,589.86
Income from THE JOURNAL	7,695.21
Interest received	1,727.90
Miscellaneous	17,544.45
TOTAL INCOME	$62,557.42
EXPENSES	
Administrative and general	$23,883.47
Society activities	14,008.32
Committee expenses	6,764.74
TOTAL EXPENSES	$44,656.53
EXCESS OF INCOME OVER EXPENSES	$17,900.89
Other deductions	43.75
NET INCOME	$17,857.14

Accounts receivable for advertising were analyzed as to month of charge and are shown as follows:

	December 28, 1945	
MONTH OF CHARGE	*Amount*	*Per Cent*
October, November, and December	$3,951.12	86.26%
July, August, and September	324.97	7.09%
January to June, inclusive	241.99	5.29%
Prior to January 1st	62.28	1.36%
TOTAL	$4,580.36	100.00%

Our examination of accounts receivable as of December 28, 1945, included tests of the balances by communication with selected debtors. It is our opinion that the reserve of $100.00 is sufficient for losses anticipated in collection of the accounts.

Securities

The changes in securities during the year were as follows:

Balance at December 30, 1944		$47,092.28
ADDITIONS		
United States Savings Bonds purchased from Michigan National Bank at issue price:		
Series G, 2½%, maturing February 1, 1957	$22,600.00	
Series G, 2½%, maturing June 1, 1957	5,000.00	
Series G, 2½%, maturing December 1, 1957	1,000.00	
Increase in redemption value of United States Savings Bonds acquired in prior years	392.70	28,992.70
		$76,084.98
DEDUCTIONS		
Securities called for redemption and surrendered for cash during the year:		
Consumers Power Company, 3¼%, maturing November 1, 1966	$ 1,020.00	
Consolidated Oil Corporation, 3½%, maturing June 1, 1951	1,063.75	2,083.75
Balance at December 28, 1945		$74,001.23
Represented by:		
Securities held by the Society		$52,457.20
Securities held by the trustee for the Postgraduate Medical Education Foundation		21,544.03
Balance at December 28, 1945		$74,001.23

Securities owned at December 28, 1945, have been stated at cost. We inspected the securities held by the Society. The securties held by the Michigan National Bank, trustee for the Postgraduate Medical Education Foundation, were confirmed to us by the trustee. We accounted for the income from all securities for the period. At December 28, 1945, aggregate market prices of securities held by the Society were $1,155.05 in excess of cost, and the aggregate market prices of securities held by the trustee for the Postgraduate Medical Education Foundation were $114.41 in excess of cost. Details of the securities are shown in a schedule in this report.

Michigan Foundation for Medical and Health Education

The assets held by the trustee for the Postgraduate Medical Education Foundation at December 28, 1945, are shown separately in the balance sheet and the unexpended balance of the trust funds is shown under a separate caption in the liability section. A non-profit corporation, sponsored by the Society, was organized during the period under Michigan laws as the Michigan Foundation for Medical and Health Education, Inc., for the purpose of carrying out a broad educational program relating to medical and health matters. The activities of this new organization will encompass the work of the Postgraduate Medical Education Foundation. During the period under review, the Executive Committee of the Council of the Society ordered the diversion to this new corporation of certain potential cash receipts of the Society which would have been deposited with the trustee for the Postgraduate Medical Education Foundation. The Executive Committee also authorized the trustee to transfer the assets held by it to the Michigan Foundation for Medical and Health Education, Inc. At December 28, 1945, the details of this transfer had not been completed. Our examination was restricted to the accounts of Michigan State Medical Society, and we have made no examination of records of the Michigan Foundation for Medical and Health Education, Inc.

During the period covered by our examination the Society received $17,544.45 from Michigan Medical Service representing payment of organizational expenditures made by Michigan State Medical Society. A full reserve had been provided therefor in prior years and the entire amount has been included as income in the income and expense statement for the period from December 30, 1944, to December 28, 1945.

Dues of Military Members Waived

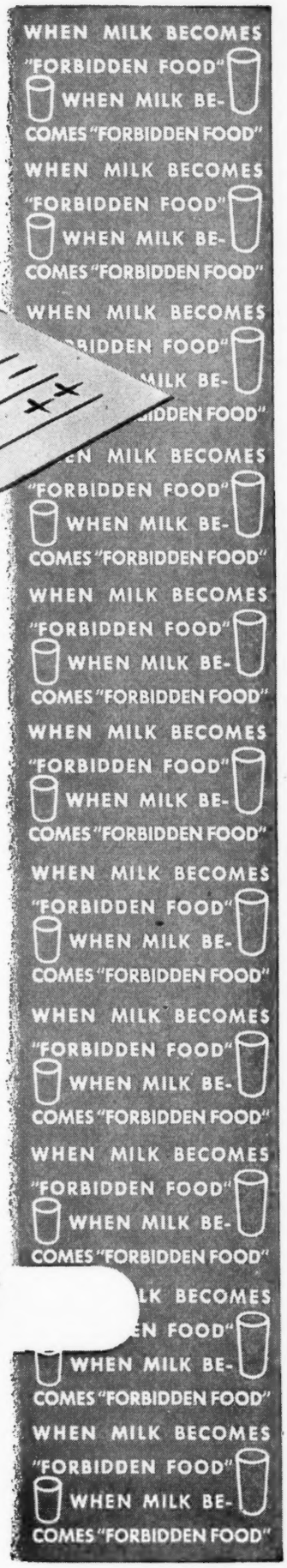
The Society has continued its policy of waiving payment of dues of members in military or naval service and, in the event the dues were paid for the year of induction, to allow free membership for a designated period following discharge. The provision made in prior years for the deferment of income received from such members is sufficient to provide those now in the services, or recently discharged, who entered service as currently paid-up members of the Society.

A statement of the income and expenses of the Public Education program conducted by the Society is included in this report. The unexpended balance of the funds assessed for this purpose has been reflected in a reserve in the accompanying balance sheet.

$16,871 Returned to County Medical Societies

On November 8, 1945, the Executive Committee of the Council authorized the return to the various county societies of the special assessment of $5.00 per capita authorized previously for the purpose of financing a medical veterans' readjustment program. At December 28, 1945, $16,871.25, representing all receipts during the period from this assessment, had been returned.

(Continued on Page 388)



Bridge the "nutritional gap"

The nutritional benefits of milk need not be deprived the "milk-sensitive" patient, even though successful treatment demands complete elimination of the offending food from the diet.

Clinical evidence has established MULL-SOY as an effective hypoallergenic substitute for cow's milk. This concentrated, emulsified soy bean food—homogenized and sterilized—closely approximates cow's milk in protein, fat, carbohydrate and mineral content. It is palatable, well tolerated, easy to digest and easy to prepare. Infants (particularly) thrive on MULL-SOY, and take it readily.

Write for copies of "TASTY RECIPES FOR MULL-SOY IN MILK-FREE DIETS", for your milk-allergic patients.

BORDEN'S PRESCRIPTION PRODUCTS DIV., 350 MADISON AVE., NEW YORK 17, N. Y.

MULL-SOY

HYPOALLERGENIC SOY BEAN FOOD

ACCEPTED AMERICAN MEDICAL ASSN

MULL-SOY is a liquid emulsified food prepared from water, soy bean flour, soy bean oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt and soy bean lecithin, homogenized and sterilized. Available in 15½ fl. oz. cans at all drug stores.

MICHIGAN STATE MEDICAL SOCIETY

BALANCE SHEET—December 28, 1945

ASSETS

Cash		
Demand deposits	$ 9,231.16	
Cash for deposit	319.46	
Office cash fund	5.27	
Savings deposits	33,252.87	
		$ 42,808.76
Accounts Receivable		
For advertising	$ 4,580.36	
For space at annual session	108.00	
For dues	44.00	
	$ 4,732.36	
Less reserve	100.00	
		4,632.36
Securities		
Bonds—at cost		52,457.20
Postgraduate Medical Education Foundation		
Note A		
Bonds—at cost	$21,544.03	
Cash	1,856.83	
		23,400.86
		$123,299.18

LIABILITIES

Accounts Payable		
For current expenses, etc.	$11,061.05	
Exhibitors' duplicate payments	259.50	
Payroll taxes	63.50	
		$ 11,384.05
Unearned Income		
Dues for the year 1946	$ 444.00	
Space sales for 1946 annual session	360.00	
Dues of military members applicable to a future year	14,100.00	
		14,904.00
Postgraduate Medical Education Foundation		
Unexpended balance of trust funds		23,400.86
Reserve		
For Public Education Program		12,150.00
Surplus		
Balance at December 30, 1944	$43,603.13	
Net income for the period from December 30, 1944, to December 28, 1945	17,857.14	
		61,460.27
		$123,299.18

INCOME AND EXPENSE STATEMENT

From December 30, 1944, to December 28, 1945

Income:		
Membership fees	$40,674.00	
Less portion allocated to income of *The Journal* for subscriptions	5,084.14	
		$35,589.86
Income from The Journal		7,695.21
Interest:		
On securities	$ 1,371.87	
On savings deposits and time certificates of deposit	356.03	
		1,727.90
Recovery of funds advanced to Michigan Medical Service charged off in a prior year		17,544.45
Total Income		$62,557.42
Expenses:		
Administrative and general	$23,883.47	
Society activities	14,008.32	
Committee expenses	6,764.74	
		44,656.53
Excess of Income Over Expenses		$17,900.89
Other Deduction:		
Loss on sale of bond		43.75
Net Income		$17,857.14

RECEIPTS AND DISBURSEMENTS OF POSTGRADUATE MEDICAL EDUCATION FOUNDATION

From December 30, 1944, to December 28, 1945

Balance at December 30, 1944		$18,210.56
Receipts:		
Contributions Received:		
From Estate of Andrew P. Biddle, M.D.	$4,622.90	
From anonymous donor	100.00	
		4,722.90
Interest on securities		542.50
Profit on sale of bond		32.50
		$23,508.46
Disbursements:		
Trustee's fees to December 15, 1945	$ 107.35	
Postage on bond sold	.25	
		107.60
Balance at December 28, 1945		$23,400.86

INCOME AND EXPENSE OF PUBLIC EDUCATION PROGRAM

From December 30, 1944, to December 28, 1945

Reserve balance at December 30, 1944		$13,363.77
Income:		
From assessment of the membership		33,875.00
		$47,238.77
Expenses:		
School of Information	$ 2,515.93	
Purchase of pamphlets	386.74	
Michigan Health Council	5,000.00	
Radio and newspaper programs	25,923.44	
Publicizing radio and newspaper programs	1,168.00	
Miscellaneous	94.66	$35,088.77
Reserve Balance at December 28, 1945		$12,150.00

(Continued on Page 390)

INCOME FROM THE JOURNAL OF MSMS

From December 30, 1944, to December 28, 1945

INCOME:	
Subscriptions from members	$ 5,084.14
Other subscriptions	160.50
Advertising sales	39,444.56
Reprint sales	1,003.95
JOURNAL cuts	130.57
	$45,823.72
EXPENSES:	
Salaries	$ 7,200.00
Editor's expense	1,200.00
Printing and mailing	19,241.36
Cost of reprints and cuts	879.05
Discounts and commissions on advertising sales	7,408.10
Allocation of administrative and general expense	1,800.00
Postage	400.00
	$38,128.51
NET INCOME	$ 7,695.21

EXPENSES

From December 30, 1944, to December 28, 1945

ADMINISTRATIVE AND GENERAL:	
Salaries—administrative	$ 5,600.00
Salaries—office	4,640.41
General counsel	8,105.55
Office rent and light	1,443.62
Printing, stationery, and supplies	938.77
Postage	637.89
Insurance and fidelity bonds	1,633.73
Auditing and system service	820.83
Repairs	15.00
Telephone and telegraph	1,526.92
Michigan sales tax	65.25
Payroll taxes	154.43
Miscellaneous	101.07
	$25,683.47
Less expenses redistributed to JOURNAL	1,800.00
	$23,883.47
SOCIETY ACTIVITIES:	
Administrative salaries allocable to annual session expense	$ 3,585.00
Council expense	4,808.34
Delegates to American Medical Association	214.84
County Secretaries' Conference	14.10
General society travel expense	1,886.67
Officers' travel expense	1,786.53
Secretary's letters	594.73
Publication expense	62.10
Reporting annual session	313.57
Legal expense	75.00
Sundry society expense	235.47
	$13,576.35
Net revenue (expense**) of annual session	431.97**
	$14,008.32
COMMITTEE EXPENSES:	
Legislative	710.32
Distribution of medical care	..
Joint committee on health education	..
Postgraduate medical education	2,800.57
Preventive medicine	57.45
Cancer control	644.18
Child welfare	..
Iodized salt	..
Heart and degenerative diseases	15.00
Industrial health and clinic	518.55
Maternal health	26.64
Mental hygiene	..
Radio	..
Venereal disease control	53.60
Tuberculosis control	..
Public relations	42.00
Ethics	37.83
Scientific work	5.37
Procurement and assignment of doctors of medicine	79.56
Prelicensure medical examination	..
Medical veterans' readjustment program	153.80
Postgraduate subcommittee on postwar education	154.91
Medical advisory committee on rehabilitation	101.93
Postgraduate foundation	136.73
Uniform fee schedules with government agencies	595.46
Rheumatic fever and conference	520.31
Sundry other committees	110.53
	$ 6,764.74
TOTAL	$44,656.53

Opinion

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of Michigan State Medical Society at December 28, 1945, and its income and expenses for the period from December 30, 1944, to December 28, 1945, in conformity with the generally accepted accounting principles applied on a basis consistent with that of the preceding period.

ERNST & ERNST
Certified Public Accountants

January 12, 1946

No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

SIMILAC } SIMILAR TO BREAST MILK

M & R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO

Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

STUDY ON FLUORINE AND DENTAL CARIES

In six Michigan towns where the water supply contains fluorine, the school children have healthier teeth than children in five towns whose water supply does not have fluorine. This study of the dental conditions of 866 children was conducted by dentists of the Michigan Department of Health.

School children in the non-fluorine areas had nearly three times as much tooth decay as children who had used flourine-containing water all their lives—an average of 5.7 decayed teeth per child against 2.2.

Towns included in the study whose water supply contains one part pjer million or more of fluorine are: Carleton, Columbiaville, Memphis, Belleville, Richmond and Fowler. In these towns 410 school children were given complete dental examinations. Towns whose water supply contains no flourine are: Edmore, Lawton, Lake Odessa, Maple Rapids and Bronson. A total of 456 school children from this group was examined.

Results of this Michigan study agree with those reported by the U. S. Public Health Service in other areas. It has been found that teeth decay less frequently among persons who, for the first eight years of life, drink water which naturally contains fluorine.

Michigan is now conducting a study to determine whether fluorine, artificially added to the water supply, will reduce the amount of tooth decay. For the past year, one part per million flourine has been added to the Grand Rapids city water supply, and a careful check is being kept on the dental conditions of school children.

USE OF PLASMA INCREASES

Use of Michigan's free blood plasma increased 40 per cent in January, according to records of the Michigan Department of Health which show that 1,402 units of plasma were distributed compared to the previous six-month average of 1,004. During January 604 patients were treated with plasma compared to 459, the average for the preceding six months.

With present equipment the laboratories can process sufficient plasma to meet this increase; the only problem is to secure sufficient blood donors.

No disaster or sudden need from one locality accounted for this jump in plasma use; it was a statewide trend. Several hospitals explained that their increased need was due to physicians returning from the armed services.

Principal uses of plasma in Michigan have been for the treatment of shock resulting from accidents, burns, surgical operations or childbirth, and for nourishing infants and premature babies.

Michigan was the first state to make blood plasma available free to any citizen needing it. The program began in September, 1943, as a joint project of the American Red Cross, which solicits blood donors, and the Michigan Department of Health which collects the blood and processes it into plasma. At present free plasma is distributed by 146 hospitals serving 76 counties. The plasma is returned to the county from which the blood is donated.

GAMMA GLOBULIN USE RISES WITH MEASLES INCIDENCE

As Michigan's 1946 epidemic of measles got under way in January, demand for gamma globulin hit an all-time high with 2,039 vials sent out from the Michigan Department of Health. During the previous six months only 1,347 vials had been requested.

In January 2,236 cases of measles were reported against 90 for January, 1945.

1945 BIRTHS AND DEATHS DECREASE

Both births and deaths in Michigan dropped slightly in 1945. There were 111,950 babies born compared to 113,681 in 1944. In 1943, record-breaking year for new babies, there were 125,441 births recorded in Michigan. This decrease in birth rate is in line with a nation-wide trend.

The 1945 death rate of 9.98 is exactly the average death rate for the previous five years in Michigan. The 1945 deaths totaled 53,650 compared to 54,000 the previous year and 56,774 for 1943.

CASES OF CERTAIN COMMUNICABLE DISEASES

	January 1946	January 1945	Seven Year median
Diphtheria	48	63	27
Gonorrhea	1,276	861	551
Lobar Pneumonia	127	109	341
Measles	2,451	90	1,384
Meningococcic meningitis	34	24	3
Pertussis	466	370	1,077
Poliomyelitis	5	1	1
Scarlet fever	543	1,056	1,031
Syphilis	1,422	1,263	909
Tuberculosis	310	418	402
Typhoid	5	3	3
Undulant Fever	6	8	8
Smallpox	0	3	1

SUMMARY OF THE EMIC PROGRAM IN MICHIGAN

From May 27, 1943, the date when the Emergency Maternity and Infant Care program was started in Michigan, to January 1, 1946, the Michigan Department of Health received 44,284 applications for maternity and pediatric care for wives and infants of servicemen in the lowest four pay grades of the armed forces, of which 38,519 were authorized for care, including medical, hospital and nursing care. At the beginning of the program a separate count was not kept of maternity and pediatric cases, but in February, 1944, the case load

(Continued on Page 412)

Woman's Auxiliary

For the first time since the state and county medical society Auxiliaries were organized in 1927, the State Executive Board met in Saginaw on January 8, 1946. A luncheon at 12:30 P.M. was held at the Bancroft, followed by the Midyear Board meeting.

MRS. HARVIE

Mrs. L. C. Harvie, president, conducted the meeting. Mrs. Guy L. Kiefer, honorary president, gave a few words of welcome and encouragement. The regular order of business followed. Reports from the county presidents were given.

Mrs. Harvie and Mrs. R. H. Alter divided the reports on the district meeting in Chicago.

Mrs. Harvie gave quotations from the address by Dr. Joseph S. Lawrence, Executive Director of the Washington AMA Office to the National Conference of the Woman's Auxilary to the A.M.A. in Chicago, December 5, 1945. Discussing the new Wagner-Murray-Dingell Bill, Dr. Lawrence stated:

"It makes no provisions for financing. . . . A Congressman from Vermont said that in England it was found necessary to employ one inspector for each 100 patients." "With our population of 130,000,000, if we had one inspector for each 1,000 patients, the government would have to employ *130,000* inspectors—these would be supervised over—all pyramiding up into Washington. Washington, of course, would supervise drugs, et cetera, employing another *130,000*; auditors estimated conservatively at *100,000;* statisticians to determine how many people ill, how many beds, et cetera. . . . *10,000* of these; stenographers, clerks, telephone operators and others . . . approximately *150,000* . . . a conservative total of *520,000.* Figuring 520,000 on an average salary of $3,000, it would cost the government more than one and one-half billion dollars—AND NOT YET THOUGHT OF THE PATIENT.

"Then, there is printing of forms, rentals, publicity, et cetera, so, if this bill were to become law, we would add to our national debt at least $5,000,000,000 annually for medical care, and only one-half of that would really be for medical care.

"If this bill goes into effect, we won't have hospital facilities, we won't have doctors and nurses to care for the patients and that will be a great disappointment.

"An insurance man estimated that the operation of the WMD Bill would cost this government in the vicinity of 15 billion dollars annually."

Regarding S191, Hospital Construction Bill approved by the A.M.A., Dr. Lawrence stated: "It is a most excellent bill, but most excellent as it is, it will be hard to pass it; however, I think it will pass." (This offers $5,000,000 for surveys, et cetera.)

Write Dr. Lawrence for information regarding medical legislation. Send him any good material, cartoons, et cetera. Ask him to make a personal call on your Congressman in Washington. He will gladly do this. His address is: Dr. Joseph S. Lawrence, 1835 Eye St., N. W., Washington 6, D. C. Telephone: Ex. 3257 or Republic 4-600 Ex. 900.

Following this business meeting of about 35 members, officers, committee chairmen, and county presidents, a tea was served by the Saginaw County Auxiliary members, honoring the State Board members.

Mrs. Harvie had as her guests all who could possibly stay over for a dinner meeting in Frankenmuth. About twenty were present. Mrs. Alter's car caught fire, and Mrs. Kiefer, as usual, was in the middle of all the excitement. However, none was hurt, and the damage to the car slight and the return trip was made following the dinner.

* * *

BAY COUNTY

Twenty-four members of the Bay County Auxiliary met at the home of Mrs. T. G. Wilson, in October.

At the business meeting the group voted to contribute to the War Chest and Community drive, to send *Hygeia* magazine to all high schools in the county, the Y.M.C.A. and Y.W.C.A., the Civic League and Bay City Junior College. Bridge was played during the social hour. Mrs. G. M. Brown won the prize.

The November meeting was held in the doctors' staff room at General Hospital. Dr. Harold H. Heuser showed movies taken in Africa, and in northern Michigan, and a travelog from the Greyhound Bus Lines.

At the December meeting held in the staff room at General Hospital, the evening was spent in playing games.

Twenty-one members of the Auxiliary met at the home of Mrs. J. W. Wilcox for the January meeting. Dessert was served and the business meeting followed. Mrs. C. L. Hess, president, conducted the meeting. Mrs. T. G. Wilson reviewed an article on heart disease from *Hygeia,* and Mrs. W. S. Stinson discussed an article on cancer from *Hygeia.* Mrs. M. R. Slattery and Mrs. V. H. Dumond served on the committee.

* * *

ST. CLAIR COUNTY

Mrs. A. L. Callery was elected president of the Auxiliary of the St. Clair County Medical Society at the meeting following a buffet dinner in the home of Mrs. Clyde S. Martin, the first of the winter series of bridge dinners. Mrs. K. B. LeGalley was elected vice president; Mrs. Edgar C. Stites, president-elect; Mrs. Charles L. Borden, secretary, and Mrs. W. E. B. Hall, treasurer.

* * *

Dr. F. T. Andrews has been appointed chairman of the Advisory Committee to the Women's Auxiliary.

* * *

Please send Auxiliary news to the Press Chairman, Mrs. A. D. Allen, 2309 Nurmi Drive, Bay City, Michigan.

* * *

Where Is Your Auxiliary's News?

What's What

The attention of all members of the Society is invited to the 1945 audit of the Michigan State Medical Society, certified by Ernst & Ernst. See pages 382, 386, 388 and 390.

* * *

The American Board of Ophthalmology announces its 1946 examinations will be held in San Francisco, June 22-25, 1946. The Secretary is S. Judd Beach, M.D., Portland, Maine.

* * *

J. W. Savage, former Executive Secretary of the West Virginia Medical Association, has been appointed Executive Director of the National Foundation for Infantile Paralysis .

* * *

A. J. Baker, M.D., Grand Rapids, addressed the Ionia Rotary Club on March 20. His subject was "The Facts About Socialized Medicine." Dr. Joseph Johns of Ionia was Program Chairman.

* * *

J. W. Hirschfeld, M.D., and *Matthew A. Tilling, M.D.,* Detroit, are co-authors of an article, "In Vitro Action of Streptomycin on Bacteria," which was published in *JAMA* of January 12.

* * *

LeMoyne Snyder, M.D., Lansing, and *Wm. J. Burns,* Executive Secretary of the Michigan State Medical Society, have been appointed as members of the Committee on Medical Jurisprudence of the State Bar of Michigan by President Ben O. Shepherd.

* * *

The financial records of the Michigan State Medical Society are audited annually by Ernst & Ernst, certified public accountants. The last audit was made as of December 30, 1945, and the report appears in this issue of JMSMS.

* * *

The American Association for the Study of Goiter will hold its annual meeting at the Drake Hotel, Chicago, June 20, 21, 22. Those who desire to read papers or to learn about the Van Meter Prize Award may contact S. F. Haines, M.D., Mayo Clinic, Rochester, Minnesota.

* * *

The American Association of Industrial Physicians and Surgeons invites MSMS members to enter its competitive scientific exhibit award, to be held in connection with the Industrial Health Conference at the Sherman Hotel, Chicago, April 8-13, 1946. For complete information, write H. Glenn Gardiner, 28 E. Jackson Blvd., Chicago 4, Illinois.

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L. J. Gariepy, M.D., and *Paul C. Henley, M.D.,* Detroit, are authors of an original article "Acute Suppurative Appendicitis with Abscess Formation and Subsequent Perforation of the Anterior Abdominal Wall" which appeared in the *American Journal of Surgery,* December, 1945.

* * *

L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, has been invited to be guest speaker at the Convention of the National Council of Catholic Nurses, in Toledo, on May 24. Dr. Foster's subject will be "The Changing Trend in Medical Care and What It Means to the Nurse."

* * *

John S. DeTar, M.D., Milan, Chairman of the MSMS Public Relations Committee, spoke March 17 before the Charles Wesley Club of First Methodist Church, Ann Arbor, on "The Evils of Socialized Medicine."

* * *

The Cancer Clinic of the Genesee County Medical Society, held March 20 in Flint, attracted a registration of 261 doctors of medicine. At the public meeting, following the day's clinic, 125 laymen were present. The Genesee County Medical Society voted to make the Cancer Clinic an annual event.

* * *

Dorothy Thompson, the columnist, says: "Co-operative medical schemes are voluntary, efficient, cheap of administration, and cheap for the participants, and could be standardized on a high level. State schemes are bureaucratic, heartless, and open to dangerous collusion between assembly-line physicians and patients at the public cost—as those know who have lived under them."

* * *

Doctor, how do you like the new type (Baskerville) being used in Volume 45 of JMSMS? Also, does the new style cover—without "curlycues"—meet with your approval? The 1946 JMSMS has been modernized, throughout, from cover to cover. Your publication is featuring more scientific articles and additional socio-economic information. This, together with the up-to-date format of JMSMS, makes it a leader among state medical society publications.

* * *

Samuel J. Nichamin, M.D. Detroit, while on active duty with the U. S. Public Health Service at Memphis, Tenn., was the author of a paper published in the *Journal of the American Medical Association,* October 27, 1945, entitled "Clinical and Epidemiological Aspects of Epidemic Pleurogynia." In the *Journal AMA* of February 17, 1945 appeared a paper in which he collaborated with three others, entitled, "Early Immunization against Pertussis with Alum Precipitated Vaccine."

* * *

The Victory Banquet of Mount Carmel Mercy Hospital, Detroit, was held at the Statler Hotel, Detroit, on January 30. Two hundred and thirty-seven guests were present to hear Congressman George A. Dondero speak on "Economic Conditions in Europe" and Professor Andrew A. Lobanov-Rostovsky of the University of Michigan answer the question: "Will Peace Come to Asia?" Henry L. Smith, M.D., Detroit, was toastmaster, and

(Continued on Page 400)

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was assisted by the Clinic and Program Committee: L. J. Gariepy, M.D., Henry J. Kehoe, M.D., Arthur K. Northrop, M.D., Herbert Naylor, M.D., and M. H. Miller, M.D.

* * *

James F. Darby, M.D., St. Ignace, celebrated fifty years of medical practice in Mackinac County on February 13. Dr. Darby, at the age of seventy-four, is still in active practice. He was born in Dresden, New York, August 29, 1871. He was graduated from the Michigan College of Medicine and Surgery, Detroit, in 1895, and started practicing in St. Ignace in 1896.

Dr. Darby was honor guest at an American Legion banquet on the fiftieth anniversary of his arrival in St. Ignace.

* * *

The Second Councilor District Meeting was held in Jackson on Tuesday, February 19. Physicians from Jackson, Ingham, Hillsdale, Lenawee and Calhoun Counties were present. R. S. Morrish, M.D., Flint, President of the Michigan State Medical Society, spoke on "This Day of Medical Transition." L. Fernald Foster, M.D., Bay City, State Society Secretary, discussed "Modern Medical Public Relations."

"Michigan's Plan for Home-Office Medical Care of Veterans" was explained by J. C. Ketchum, Detroit, Executive Vice President of Michigan Medical Service. This veteran care program, to relieve congestion in government facilities for veterans having service-connected disabilities, has already enlisted the co-operation of 3,000 Michigan practitioners, according to Mr. Ketchum. The plan makes possible periodic examination or treatment of such veterans by their own physicians. The initial contract with Michigan Medical Service covered home-office medical care, but a later contract between the Veterans Administration and Michigan Hospital Service included hospitalization for veterans, effective April 1.

O. O. Beck, M.D., Birmingham, Vice Chairman of the MSMS Council, spoke on "The Fourteen Firsts of Michigan."

J. S. DeTar, M.D., Milan, Vice Speaker of the MSMS House of Delegates urged the need for personal contacts by physicians with their patients in presenting facts on socio-economic problems.

One hundred and thirty-two physicians were in attendance.

* * *

Prize Essay Contest

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For information address—Dr. Jas. R. Bloss, Secretary, 418 11th Street, Huntington 1, W. Va.

* * *

Michigan Plan

The North Carolina Eye, Ear, Nose and Throat Society, September 7, 1945, adopted a set of resolutions calling upon the President of the North Carolina State Medical Society to appoint a committee to study medical

(Continued on Page 402)

(Continued from Page 400)

and hospital insurance plans and included the following, "That this committee make a particular study of the 'Michigan Plan.'"

* * *

Central States Dermatological Society

The next meeting of the Central States Dermatological Society will be held in Detroit, at Harper Hospital on April 27, 1946, with clinics beginning at 2:00 p. m. C. E. Reyner, M.D., Henry Ford Hospital, is secretary-treasurer, to whom communications should be addressed.

* * *

Quarterly Review of Pediatrics

The *Quarterly Review of Pediatrics,* a new publication, is announced to appear in February, May, August and November. Medical articles of interest to pediatricians will be abstracted as soon after publication as possible and presented in this journal. The *Review* will serve also as a guide to original sources for more intensive study. The Editor-in-Chief is Irving J. Wolman, M.D., The Children's Hospital, Philadelphia 46, Pa.

* * *

National Science Foundation

S. 1720 was introduced by Mr. Kilgore of West Virginia (for himself, Mr. Johnson of Colorado, Mr. Pepper of Florida, Mr. Fulbright of Arkansas and Mr. Saltonstall of Massachusetts), December 21. This is a bill to promote the progress of science and the useful arts, to secure the national defense, to advance the national health and welfare, and for other purposes, and was referred to the Committee on Military Affairs.

Comment.—Subsequent to the hearings accorded the earlier bills providing for the subsidizing of scientific work by the Federal government, Mr. Kilgore drafted a new bill to be entitled, "The National Science Foundation Act of 1945." The bill provides that the Foundation shall be presided over by an administrator and a deputy administrator to be appointed by the President. There are to be at least eight divisions, one of which will be a Division of Health and Medical Sciences, and each to be headed by a director appointed by the administrator. The administrator will consult and advise with the chairmen of the scientific divisions and the national science board, consisting of nine members appointed by the President. The administrator is authorized to award scholarships and fellowships to persons for scientific study or scientific work at non-profit institutions.

* * *

TWENTY-FIFTH ANNIVERSARY—HIGHLAND PARK GENERAL HOSPITAL

The Highland Park General Hospital will celebrate its twenty-fifth anniversary by holding an all-day clinic on April 24, 1946, ending the day with a guest speaker and banquet at the Wardell-Sheraton Hotel.

Morning Session—8:30 A. M.

Clinical Pathological Conference

"Streptomycin"—Edw. N. Cook, M.D., Mayo Clinic, Rochester, Minn.

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(Continued from Page 402)

"Diabetes in Pregnancy"—Priscilla White, M.D., Boston, Massachusetts.

"Newer Aspects of Endometriosis"—James Goodall, M.D., Montreal, Canada.

"Endometriosis"—James R. Goodall, M.D., Montreal, Canada.

Luncheon—1:00 P. M.

Plate luncheon, courtesy of Highland Park General Hospital.

Afternoon Session—2:00 P. M.

"Functional Consequences of Coronary Occlusion"—Carl Wigger, M.D., Cleveland, Ohio.

"Surgical Treatment of Gastric Lesions"—Samuel F. Marshall, M.D., Surgeon Lahey Clinic, Boston, Massachusetts.

"Notes on the Surgical Management of Cancer of the Colon and Rectum"—Fred Rankin, M.D., Brig. Gen. U. S. Army, Chief Consultant in Surgery, Lexington, Kentucky.

Speaker—To be announced.

Cocktail Hour—7:00 P. M.

At the Wardell-Sheraton Hotel

Evening Banquet—7:30 P. M.

At the Wardell-Sheraton Hotel

Plinn W. Morse, M.D., Toastmaster.

Presentation of Oil Portrait of Frank C. Witter, M.D., to Hospital

Guest Speaker—Floyd K. Armstrong, Professor Emeritis Economics and Finance, M.I.T.

There will be no fee for the Clinic. Tickets for the banquet will be $5.00 each. Dr. Frank Witter is chairman of the Committee on Arrangements.

* * *

INDUSTRIAL PHYSICIANS AND SURGEONS

The annual meeting of Industrial Physicians and Surgeons will be held in Grand Rapids, March 27, 1946. Following is the tentative program:

Morning Session

(Grand Rapids Stamping Division of General Motors Corp.)

9:30 a.m. Registration.

10:00 a.m. Program.

Afternoon Session

"Thoracic Trauma"—Wm. McC. Tuttle, M.D., Detroit.

"Tendon Surgery of the Hand"—Michael L. Mason, M.D., Chicago.

"Occupational Restoration Following Trauma"—H. D. Storms, M.D., Director, Rehabilitation Clinic, Ontario Workmen's Compensation Board.

Evening Session

President's Address—Leon E. Sevey, M.D., Grand Rapids.

"A Doctor in Industry" (A motion picture.)

Correspondence

Editor, Journal, Michigan State Medical Society:

The editorial article which appeared in the January 5 issue of the *AMA Journal* concerning work done by Dr. Preioni of Argentina entitled: "The Relation of Infantile Paralysis in Epizootic Avian Paralysis" seems to support my theory as to the possibility of the virus being carried by swallows. Reference: my communique in the May, 1945, issue of the MICHIGAN STATE MEDICAL JOURNAL.

For the past year and a half I have been trying to stimulate the interest of investigators in a bug described in a library reference book by Barrows, entitled "Michigan Bird Life."—Quotation from Page 543.

"It is a common belief among country people that the Martin brings bed bugs to its nesting place and in that way houses and barns become infested. The only foundation for this belief lies in the fact that a peculiar bug belonging to the same family as the bed bug does infest Martins' nests and is doubtless carried from place to place by the birds. This insect, however, is not the bed bug and cannot live on other animals than swallows. There is, therefore, no danger of its infesting dwelling houses."

Note: The only habitat of this bug is the swallow.

Now Dr. Preioni has shown that avian paralysis simulates or is the same as poliomyelitis and he states that he believes infantile paralysis to be spread by the bite of a louse which has become infected by biting an infected bird.

With this in mind, I am writing this communique in the hope of stimulating interest in the possibility of birds and particularly swallows being the carriers of the virus, and also in the hope that I may get someone to investigate the described bug which might be the intermediary host.

I am also writing to Dr. Preioni of Argentina to arouse his further interest in this matter.

RANDALL M. O'ROURKE, M.D.

Epidemiology of Tinea Capitis in Detroit School Children

(Continued from Page 352)

16. Lewis, G. M., Silvers, S. H., Cipollars, A. C., Muskablit, E., and Mitchell, H. H.: Measures to prevent and control an epidemic of ringworm of the scalp. New York State J. Med., 44:1327, 1944.
17. Livingood, C. S., and Pillsbury, D. M.: Ringworm of the scalp: prolonged observation, family investigation, cultural and immunologic studies in 130 cases. J. Invest. Dermat., 4:43, 1941.
18. Margarot, J., and Devèze, P.: Aspect de quelques dermatoses en lumière ultraparaviolette, note preliminaire. Bull. Soc. d. sc. méd. et biol. de Montpellier, 6:375, 1925.
19. Mook, W. H.: Cited by Lewis, G. M.[14]
20. Radley, J. A., and Grant, J.: Fluorescence Analysis in Ultraviolet Light, p. 26. New York: D. Van Nostrand Co., Inc., 1933.
21. Smith, L. M.: Cited by Lewis, G. M.[14]
22. Weidman, F. D.: Cited by Lewis, G. M.[14]
23. Wende, G. W.: Cited by Corlett.[9]
24. White, C. W.: Ringworm as it exists in Boston. J. Cut. & Genito-Urin. Dis., 17:1, 1899.

THE DOCTOR'S LIBRARY

Acknowledgement of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MANUAL OF DIAGNOSIS AND MANAGEMENT OF PERIPHERAL NERVE INJURIES. By Robert A. Groff, M.D., Lieutenant Colonel, MC, AUS. Formerly Assistant Professor of Surgery, Jefferson Medical College, and Assistant Professor of Neurosurgery, Graduate School of Medicine, University of Pennsylvania. And Sara Jane Houtz, B.S., First Lieutenant (P.T.) AUS; With an Introduction by I. S. Ravdin, M.D., Brigadier General, MC, AUS; John Rhea Barton, Professor of Surgery, University of Pennsylvania. One hundred eleven original illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1945. Price $8.00.

This is a manual of diagnosis, with descriptions of the nerves involved in injury or accident, or disease, with pictures of the outlined function or loss of function. The pictures are clear and exact, giving a comprehensive understanding of the problem. Function or loss of function is illustrated, with tabulation of injuries that would be caused by the lesion. There is ample description of methods of repair, where to obtain material, and how best to accomplish the repair. Injuries or lesions of the cranial and peripheral nerves are all covered. This is an excellent manual, giving the essentials that are needed for diagnosis, and outlining of repair or physical restoration.

EVERYDAY PSYCHIATRY: Concise, Clinical, Practical. By John D. Campbell, M.D., Commander, MC, USNR; Chief Neuropsychiatrist, U.S. Naval Base Hospital No. 8; Formerly Chief Neuropsychiatrist, U.S. Naval Hospital, Charleston, S.C., and Visiting Lecturer in Psychiatry, Medical College of South Carolina; Diplomate American Board of Neurology and Psychiatry. Designed for Practitioners and Students. Philadelphia, London, Montreal; J. B. Lippincott Company, 1945. Price $6.00

Diagnosis and treatment of mental disease is a problem for every doctor of medicine. Many phases of life enter into the field, and produce abnormal conditions. Disturbances of intelligency, emotional stability, psychosexual development, personality changes, alcoholic states, are all factors to be studied in diagnosing and treatment of mental and emotional disturbances. This book is clearly written, well told, and is a guide in psychiatric studies when the first changes are noticeable. Recognition of abnormal states early is a function of the general practitioner, who should be familiar with the materials of this text. It is written with that end in view.

MEN WITHOUT GUNS, By DeWitt Mackenzie, War Analyst of the Associated Press; Descriptive Captions by Major Clarence Warden, MC, U. S. Army; Foreword by Major General Norman T. Kirk, Surgeon General, U. S. Army. 177 Drawings including 118 Plates in full color. 152 pages. Philadelphia: The Blakiston Company, 1945. Price $5.00.

The work of the Army Medical Corps in the war has been lauded as most efficient but this book opens the scenes to the interested observer in a method impossible to understand unless personal opportunity for knowledge is given. Many famous artists have contributed of their skill to make this book one of the most beautiful and most instructive we have had the opportunity to

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see. It is a work of art, giving color pictures of the intimate, anguishing and sordid sufferings of our soldiers, and their alleviation by the devoted members of the Medical Corps. The book is a library piece you will prize.

THE EXTREMITIES, By Daniel P. Quiring, Ph. D., Head of the Anatomy Division, Cleveland Clinic Foundation, and Associate Professor of Biology, Western Reserve University; Beatrice A. Boyle, Artist, Cleveland Clinic Foundation; Erna L. Boroush, M.A., Fellow, Anatomy Division, Cleveland Clinic Foundation; Bernadine Lufkin, A.B., Former Secretary, Research Division, Cleveland Clinic Foundation. Illustrated with 106 Engravings. Philadelphia: Lea & Febiger, 1945. Price $2.75.

This book is an accumulation of diagrams showing the origin, insertion, action, arterial and nerve supply of the extremities. Function is described. References in each instance are given to Gray and Cunningham. This book will be handy in refreshing when exact knowledge is needed. It is not complete, but is exact and specific.

Tidal Irrigation

(Continued from Page 357)

ease of operation, the slight demands for nursing care, inexpensiveness, the effectiveness of bladder drainage, and the comfort of the patient.

References

1. Munro, D.: The activity of the urinary bladder as measured by a new and inexpensive cystometer. New England J. Med., 214:617, (March 26) 1936.
2. Webb, E. A.: A combined cystometer and tidal bladder irrigator. Univ. Michigan Hosp. Bull., 9:69, (Aug.) 1943.

Classified Advertising

FOR SALE: Fischer X-ray and Fluoroscopic unit in perfect order Worth $1,500; will sacrifice for $1,000. One Hanovia Ultra-violet lamp which cost $275; for quick sale will take $100. Contact FRANK A. WARE, M.D., 514 Genesee Bank Building, Flint 3, Michigan. Telephone Flint 97811.

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SUMMARY OF THE EMIC PROGRAM IN MICHIGAN

(Continued from Page 392)

of maternity cases was 94 per cent and of pediatric cases 6 per cent, as compared with a case load in December, 1945, of maternity cases 78 per cent and of pediatric cases 22 per cent.

Peak months for applications were June, 1944, with 1,825 applications and August, 1944, with 1,781 applications. It is of interest to note that for the month of January, 1946, there was a total of 1,810 applications, making that month the third highest for applications since the beginning of the program.

During the fiscal year 1944-45, there was an expenditure of approximately $595,000 to Michigan doctors for maternity and pediatric care.

The average cost per case completed during the fiscal year 1944-45 was as follows: Maternity, $105; pediatric, $62. The average number of days in the hospital for completed cases during the fiscal year was: Maternity, 9 days; pediatric, 16.9 days.

Physicians recently released from military service may receive on request to the Michigan Department of Health, Lansing, Michigan, Information Circular with complete details on the policies and procedures of the program.

JOHN M. HEPLER LECTURES IN PUERTO RICO

In response to a request from the Puerto Rico School of Tropical Medicine, John M. Hepler, C.E., director of the Bureau of Engineering, Michigan Department of Health, left February 3 for three weeks in Puerto Rico.

Mr. Hepler delivered a series of lectures on the treatment of water supplies, sewage disposal methods, and stream pollution, before the students of the School of Tropical Medicine. He will also address the Puerto Rico Public Health Association and the Caribbean Water Works Association.